7/13/92

IN THE MATTER OF THE PROPOSED AMENDMENTS OF DEPARTMENT OF HUMAN SERVICES RULES RELATED TO MENTAL HEALTH SERVICES UNDER MEDICAL ASSISTANCE, MINNESOTA RULES, PART 9505.0323 AND OF PROPOSED RULES RELATED TO MENTAL HEALTH CASE MANAGEMENT SERVICES AND HOME-BASED MENTAL HEALTH SERVICES UNDER MEDICAL ASSISTANCE PAYMENT, MINNESOTA RULES, PARTS 9505.0322 AND 9505.0324

STATEMENT OF NEED AND REASONABLENESS

for 2 sets of rules

Introduction

Parts 9505.0322 and 9505.0324 and the amendments to Minnesota Rules, part 9505.0323 are proposed by the Department of Human Services (hereafter, the Department) to establish standards and procedures for providing certain mental health services to medical assistance eligible persons with mental illness or severe emotional disturbance.

The Minnesota medical assistance program is the joint federal-state program that implements Title XIX of the Social Security Act by providing for the medical needs of low income or disabled persons and families with dependent children. (See United States Code, title 42, section 1396a, et seq.)

In compliance with the requirements of the Code of Federal Regulations, title 42, section 431.10, the Department has been designated as the state agency to supervise the administration of the state's medical assistance program and to adopt rules that must be followed in administering the State Plan. See Minnesota Statutes, section 256B.04, subdivisions 1 and 2. The State Plan is the Department's comprehensive written plan to administer and supervise the medical assistance program according to federal requirements. See 42 U.S.C. 1396 and 1396a.

Correspondingly, Minnesota Statutes, section 256B.04, subdivision 2 requires the Commissioner of the Department of Human Services to establish "uniform rules and regulations, not inconsistent with law" to ensure that the medical assistance program is carried out "in an efficient, economic, and impartial manner." The Department is further required, under Minnesota Statutes. section 256B.04, subdivision 4 to cooperate with the federal government "in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program...".

Small business concerns
In preparing these rules, the Department considered the requirements of Minnesota Statutes, section 14.115 but determined that these rules, as was found in the case of the previously adopted medical assistance rules, are exempt from these requirements according to the exemption given in section 14.115, subdivision 7, clauses (2) and (3).

Rule development procedure
In developing the proposed rules, the Department followed the procedures mandated by the Administrative Procedure Act and the department to solicit

opinion and obtain guidance from persons who will be affected by the rules when adopted. Notices to Solicit Outside Opinion were published in the State Register on December 30, 1991 (16 S.R. 1594), on February 10, 1992 (16 S.R.1886), and on February 24, 1992 (16 S.R. 1947) . The Department convened a rule advisory committee comprised of county representatives, advocates, members of the state mental health advisory council and its children's subcommittee, and providers. See Attachment 1. Members of the committee advised the Department about case management services as proposed in part 9505.0322 and parts 9520.0900 to 9520.0926. It should be noted that parts 9520.0900 to 9520.0926 are being proposed concurrently with part 9505.0322 and the amendments to part 9505.0323.

All comments on the proposed rule, including written comments received from the committee members and other members of the public were reviewed and considered by the Department as the proposed rules were drafted.

Background of Proposed Rules Related to Mental Health Case Management Services

Mental health case management services for persons with serious and persistent mental illness or severe emotional disturbance are designed to assist eligible persons in gaining access to needed medical, social, educational, and other services. See 42 USC 1396n(g) which permits the state to provide this assistance to eligible persons as optional targeted case management services. Major goals of case management services to adults are to help adults with serious and persistent mental illness gain access to needed medical, social, educational, vocational and other necessary services as they relate to the adults' needs and to ensure service coordination by a case manager responsible for monitoring the adult's progress on a continuing basis. See Minnesota Statutes, section 245.462, subdivision 3. Similar goals of case management services to children in the areas of access to and coordination of services needed by children with severe emotional disturbance and assuring continuity of the children's care are stated in Minnesota Statutes, section 245.4871, subdivision 3. Because case management services provide coordination of services and help the client obtain needed services, the client should receive improved service delivery, non-duplication of services, and early intervention when a client's mental health appears to be deteriorating.

Rules establishing standards for case management services to persons with serious and persistent mental illness, parts 9505.0476 to 9505.0491 were adopted as of December 27, 1988. These rules did not include standards applicable to case management services to persons with severe emotional disturbance.

Minnesota Statutes (1991), section 245.484, required the Department to adopt emergency rules related to case management services for children with severe emotional disturbance. The Department complied with the requirement by amending an existing rule and adopting a new rule: emergency amendments clarifying the standards for services to persons with severe emotional disturbance were made to the existing rule that sets standards for case management services to persons with serious and persistent mental illness, parts 9505.0476 to 9505.0491; and a new rule, parts 9520.0900 to 9520.0926 [emergency] set standards for case management services to children with severe emotional disturbance and their families. The emergency amendments and emergency rule became effective December 27, 1991.

The Department chose this route for several reasons. Some members of the

advisory committee stated that the mental illness of children, especially those between 18 and 21 years of age, may be characterized as either emotional disturbance or mental illness. This belief is supported by the fact that the diagnostic codes for mental illness and emotional disturbance are the same. They are code range 290.0 to 302.99 or 306.0 to 316.0 in the International Classification of Diseases (ICD-9-CM), current edition or the corresponding code in the American Psychiatric Association's Diagnostic and Statitistical Manual of Mental Disorders (DSM-MD), current edition, Axes I, II, or III. See Minnesota Statutes, section 245.462, subdivision 20 for adults and 245.4871, subdivision 15 for children. The definition of adult with serious and persistent mental illness set forth in Minnesota Statutes, section 245.462, subdivision 20 and that of child with severe emotional disturbance in Minnesota Statutes, section 245.4871, subdivison 6 are also comparable as they include criteria about inpatient treatment or residential treatment for mental illness or an emotional disturbance. Thus, amending the existing rule, parts 9505.0476 to 9505.0491 assured that medical assistance eligible children with the diagnosis of serious and persistent mental illness would be eligible for case management services on an equitable basis with children whose diagnosis was severe emotional disturbance. Additionally the Department was concerned about complying with Title 42, Code of Federal Regulations, section 440.240(b) (42 CFR 440.240(b).) 42 CFR 440.240(b) requires the State Medicaid Plan to provide services equal in amount, duration and scope to all needy persons. Persons whose mental illness or emotional disturbance fell within the same code ranges cited above comprise the group of needy persons. Thus present parts 9505.0476 to 9505.0491 and the emergency amendments to these parts set standards for case management services to which medical assistance eligible persons are entitled if they meet the criterion of serious and persistent mental illness or severe emotional disturbance. See part 9505.0476, subpart 2 as amended. At the same time as the adoption of the emergency amendments to parts 9505.0476 to 9505.0491, parts 9520.0900 to 9520.0926 [Emergency] were adopted to set case management service standards for children with the diagnosis of severe emotional disturbance without regard to a limit on the amount, duration and scope of the service other than the ability of the county having responsibility for the child to fund the services. Parts 9520.0900 to 9520.0926 [Emergency] are designed as a model of mental health case management services to children regardless of the source of the funding used by the county to purchase the service.
The service standards are similar but not identical in parts 9520.0900 to 9520.0926 [Emergency], and parts 9505.0476 to 9505.0491 and the emergency amendments thereto. For example, both rules require a diagnostic assessment of the person who requests or is referred for case management services and both rules set identical qualifications for a case manager and clinical supervision. However, the medical assistance rule (parts 9505.0476 to 9505.0491 and emergency amendments thereto) establishes service limits, exclusions, and payment rates while parts 9520.0900 to 9520.0926 [Emergency] do not have corresponding provisions.

Under Minnesota Statutes 1991, section 245.484, the Department must adopt permanent rules related to case management services for children with severe emotional disturbance by January 1, 1993. [The Department notes that under the Administrative Procedure Act, Minnesota Statutes, Chapter 14, the emergency rules and emergency rule amendments will expire on December 21,

1992.] To meet the statutory deadline and the Department's goals, the Department considered the most effective way to:
1. eliminate the duplicate provisions of these two sets of rules related to case management services to needy individuals;
2. assure continuity of case management services to eligible persons;
3. meet federal regulatory requirements about comparability of services; and
4. comply with the mandates reform legislation applicable to community social services including mental health services under Minnesota Statutes, section 256E.081 and with Governor Carlson's Executive Order 91-21.
Additionally, insofar as possible, the Department determined that standards applicable to case management services should focus on outcomes rather than procedures, that duplicative rules would be consolidated, and rule language simplified wherever possible.

Part 9505.0322 is a medical assistance rule governing eligibliity to receive medical assistance payment as a provider of case management services to medical assistance recipients. Medical assistance rules as stated above set service standards for eligible providers, services eligible for payment, and limits on the amount, duration and scope of the services as required under the federal regulations and Minnesota Statutes, section 256B.04, subdivision 12. Such rules do not focus on outcomes. A rule specifying service standards, however, offers the possibility of keeping procedural prescriptiveness to a minimum and specifying the desired outcomes of the service while at the same time leaving to the service providers the determination of the method of attaining the desired outcomes that is most appropriate for the client and feasible for the providers.

To meet these purposes, the Department has separated standards governing eligibility to receive medical assistance payment as a case management service provider from case management service standards. All service standards for the provision of case management services to adults with serious and persistent mental illness and to children with severe emotional disturbance are being proposed in one set of permanent rule parts, proposed parts 9520.0900 to 9520.0926. All medical assistance standards relating to eligible providers of case management services to recipients, and the amount, duration, and scope of the services are being proposed in part 9505.0322. Part 9505.0322 relies on the case management service standards set forth in parts 9520.0900 to 9520.0926 as medical assistance recipients comprise one of the groups of persons who may be eligible to receive case management services. It is necessary and reasonable for part 9505.0322 to be consistent with parts 9520.0900 to 9505.0926 because consistency assures a single standard of service and thereby equitable treatment of clients without regard to the sources of funding the service.

9505.0175 DEFINITIONS
Subpart 1. Scope. This is a technical amendment that is necessary because parts 9505.0476 to 9505.0491 will be repealed if proposed parts 9505.0322 and 9520.0900 to 9520.0926 and are adopted. The amendment is reasonable because it informs interested persons of the correct citations.
Subp. 27. Mental health practitioner.
Subp. 28. Mental health professional.

Amendment of these subparts is necessary because the present definitions are not consistent with the definitions in the Minnesota comprehensive mental health act. The definitions are reasonable because they inform affected persons where to find the statutory definitions applicable to mental health practitioners and professionals providing services to children and those providing services to adults. The Department notes that the proposed definition of mental health professional does not include clause (5) of Minnesota Statutes, section 245.462, subdivision 18 or clause (5) of Minnesota Statutes, section 245.4871, subdivision 27. In both statutes, clause (5) refers to a person in an allied field who meets the qualifications of a master's degree from an accredited college or university in one of the behavioral sciences or related fields and at least 4,000 hours of post-master's supervised; however, such a mental health professional is not required to be licensed in accordance with state laws. Minnesota Statutes, section 256B.0625, subdivision 24 states, "Medical assistance covers any other medical or remedial care licensed and recognized under state law unless otherwise prohibited by law..." Thus clauses (5) do not require licensure for a person defined as a mental health professional in clauses (5.) Persons who are qualified according to the requirements of Minnesota Statutes, section 245.462, subdivision 18, clauses (1) to (4) or section 245.4871, subdivision 27, clauses (1) to (4) are licensed and recognized under state law. Thus it is reasonable to limit the definition of mental health professional for medical assistance purposes to those who persons defined in Minnesota Statutes, section 245.462, subdivision 18, clauses (1) to (4) and section 245.4871, subdivision 27, clauses (1) to (4) because the definition is consistent with the requirement of Minnesota Statutes, section 256B.0625, subdivision 24.

9505.0260 COMMUNITY MENTAL HEALTH SERVICES.

Subpart 2. Item H. The amendment of item H is a technical change necessary to update the rule. Part 9505.0260 was adopted before the enactment of the Minnesota comprehensive children's mental health act, Minnesota Statutes, sections 245.487 to 245.4888, which together with the Minnesota comprehensive adult mental health act, section 245.461 to 245.486 set the standards for mental health services provided by community mental health centers. Thus the amendment is reasonable as it informs affected persons of the required standards for eligibility as a provider of medical assistance services.

Subp. 4. Payment limitation; supervision of service before September 1, 1990. The requirement stated in this subpart became obsolete on September 1, 1990. Thus it is no longer necessary and its deletion is reasonable.

9505.0322 MENTAL HEALTH CASE MANAGEMENT SERVICES
The Department notes that much of the material in this part continues without substantive change provisions that establish standards to receive medical assistance payment as a provider of case management services. These provisions are now in parts 9505.0476 to 9505.0491.
Part 9505.0322, if adopted, will be one part within the series, parts 9505.0170 to 9505.0475 which establish the eligibility standards to receive payment for health care services provided to medical assistance recipients.

Subpart 1. Definitions. This subpart is necessary to clarify terms used in this rule and set a uniform standard. A uniform standard is consistent with Minnesota Statutes, section 256B.04, subdivision 2.

Item A. The term clinical supervision describes a necessary component of case management services under this rule. Citing the statutes which define the term of clinical supervision of services to adults and children is reasonable as it reflects the Legislature's prevailing thinking which the Department is bound to follow.

Item B. This term describes one type of contact between a recipient and a service provider. Face-to-face is a commonly used term which is defined in The American Heritage Dictionary of the English Language, 1978 edition, page 469 as "in each other's presence; in direct communication." The proposed definition is consistent with the dictionary definition.

Item C. The term "mental health case management" is consistent with Minnesota Statutes, section 245.462, subdivision 3, in the case of adults, and with Minnesota Statutes, section 245.4871, subdivision 3, in the case of children. A similar definition is found in present part 9505.0477, subpart 4. Part 9505.0322 will use the abbreviation "case management service" throughout as a way to shorten the rule.

Item D. "Recipient" is a term defined in part 9505.0175, subpart 41 for purposes of parts 9505.0170 to 9505.0475 as a person determined by a local agency to be eligible for the medical assistance program. Because the definition in subpart 41 would apply part to 9505.0322 unless otherwise specified, it is necessary to clarify the term's meaning for part 9505.0322. "Recipient" is used in proposed part 9505.0322 as an abbreviation for the long phrase, "a recipient with a serious and persistent mental illness or severe emotional disturbance who has been determined by a local agency to be eligible for case management services". Using an abbreviation is reasonable because it shortens the rule.

Item E. The term "serious and persistent mental illness" describes the condition of an adult recipient who is eligible to receive case management services under this part. The definition is reasonable because it is consistent with Minnesota Statutes, section 245.462, subdivision 20. Citing the statute which defines the term of serious and persistent mental illness is reasonable as it reflects the Legislature's prevailing thinking which the Department is bound to follow.

Item F. The term "severe emotional disturbance" describes the condition of a child recipient who is eligible to receive case management services under this part. The definition is reasonable because it is consistent with Minnesota Statutes, section 245.4871, subdivision 6. Citing the statute which defines the term of severe emotional disturbance is reasonable as it reflects the Legislature's prevailing thinking which the Department is bound to follow.

Item G. The term "updating" describes an activity performed by a mental health professional as part of the required procedure to determine the recipient's continued need and eligibility for case management services. The definition is reasonable because it is consistent with Minnesota Statutes, sections 245.467, subdivision 2 and 245.4876, subdivision 2. Citing the statutes which define the term "updating" is reasonable as they reflect the Legislature's prevailing thinking which the Department is bound to follow.

Subp. 2. Determination of eligibility to receive case management services.

Minnesota Statutes, sections 245.4711, subdivision 2, paragraph (b), in the case of adults requesting or referred for case management services, and section 245.4881, subdivision 2 in the case of children require the county board to determine whether a person is eligible for case management services. The county board in turn delegates this function to the local agency. See the definition of local agency in part 9505.0175, subpart 21. This subpart is necessary to specify the required method used to determine the eligibility of potential case management clients. It continues the same requirement found in present part 9505.0480, subpart 7. See also the definitions of serious and persistent illness in subpart 1, item E and of severe emotional disturbance in subpart 1, item F. Minnesota Statutes, section 245.462, subdivision 9 states that a diagnostic assessment means "a written summary of the...diagnosis...and general service needs of an adult..." Minnesota Statutes, section 245.4871, subdivision 11 in the case of a child states that a diagnostic assessment "means a written evaluation by a mental health professional of...the child's diagnosis including a determination of whether the child meets the criteria of severely emotionally disturbed..." It is reasonable to require a diagnostic assessment before arranging for case management services because it is consistent with the prevailing thinking of the Legislature about the meaning of a diagnostic assessment which the Department is bound to follow. It also is reasonable because the diagnostic assessment will obtain information about the client's history, strengths, weaknesses, vulnerabilities and general service needs that the case manager needs to develop an individual community support plan of services for an adult recipient or an individual family community support plan of services for a child recipient. See subpart 4 which permits case management services to be provided, for up to four months, to a client who meets certain criteria before determining the client's eligibility for the services by a diagnostic assessment. These criteria are based on those in Minnesota Statutes, section 245.462, subdivision 20, paragraph (c) which specifies that an adult has a serious and persistent mental illness if the adult has a mental illness and has undergone two or more episodes of inpatient care for mental illness within the preceding 24 months, or has experienced a continuous psychiatric hospitalization or residential treatment longer thn six months duration within the preceding 12 months or has been committed by a court as a mentally ill. Similar criteria applicable to other methods of determining whether a child has a severe emotional disturbance are set forth in Minnesota Statutes, section 245.4871, subdivision 6.

Subp. 3. Required contents of a diagnostic assessment. This subpart sets the standards for a diagnostic assessment required for a determination of a person's eligibility for mental health case management services. These requirements for purposes of eligibility to receive medical assistance payment are set forth in part 9505.0323, subpart 4. Part 9505.0323 sets the parameters for mental health services under medical assistance. Minnesota Statutes, section 256B.0625, subdivision 20 authorizes mental health case management as a covered service under medical assistance. Therefore, requiring the diagnostic assessment necessary in the determination of eligibility for case management services to meet the established medical assistance requirement is reasonable because a single standard complies with the requirement to administer the medical assistance program statewide in a uniform manner as set forth in Minnesota Statutes, section 256B.04,

subdivision 2. That the diagnostic assessment identifies the needs to be addressed in the recipient's individual treatment plan is reasonable because the requirement complies with the definitions set forth in Minnesota Statutes, section 245.462, subdivision 9 and 245.4871, subdivision 11. Placing the needs in the diagnostic assessment also is reasonable because it provides written evidence about the needs and a means of monitoring whether the client needs are being met by the services in the plan.

Subp. 4. Eligibility if person does not have a current diagnostic assessment. As noted above under subpart 2, a diagnostic assessment is one criterion used to determine whether a person has a serious or persistent mental illness or a severe emotional disturbance. Other criteria are found in Minnesota Statutes, sections 245.462, subdivision 20, paragraph (c), which defines serious and persistent mental illness, and 245.4871, subdivision 6, which defines severe emotional disturbance. Subpart 4 is a new provision proposed by the Department to meet the requirement of Minnesota Statutes 1991, section 245.4711, subdivision 9. Subdivision 9 requires the Department to "revise existing rules governing case management services, in order to...make improvements in rule flexibility..". The Department responded to this requirement by adopting an emergency amendment to the current rule, part 9505.0480, subpart 14. The language of proposed subpart 4 is the same as the emergency amendment.

Item A. This item is consistent with the requirement of Minnesota Statutes, sections 245.4711, subdivision 1, in regard to the provision of case management services to adults, and 245.4881, subdivision 1, in regard to the provision of case management services to children.

Item B. The mental health condition of an adult with a mental illness or a child with an emotional disturbance may interfere with the person's ability to carry out the usual activities of daily living. These activities include using information to make decisions about necessary or required services such as a diagnostic assessment. Thus a person may refuse to comply with a requirement to obtain the diagnostic assessment required under subpart 2. Nevertheless, the adult with a mental illness or a child with an emotional disturbance may need, and be willing to accept, the assistance of a case manager in accessing, monitoring, and coordinating mental health and other services that will assist the person's functioning. Members of the advisory committee report that the mental illness of many clients makes them fearful, suspicious, withdrawn, or not open to receiving and acting on professional recommendations. Such clients sometimes express concerns about having a diagnostic assessment labelling them as having serious and persistent mental illness or the child's parent may express fear that a label of severe emotional disturbance will adversely affect the child or the parent. Members reported that by working with such clients or the parents of a child they are able to demonstrate that case management is a help rather than an intrusion and to convince the client or the child's parent that a client or the child's parent will not have to divulge information the person wants to keep confidential. At that point, the client may be ready to consent to the required diagnostic assessment. Advisory committee members report that, because of the person's mental illness, it may be difficult to establish a working relationship. The members agree time is needed to give the case manager the opportunity to gain the trust and confidence on the person so that

the person will accept the needed services and obtain a diagnsotic assessment. Therefore, this item is reasonable because it provides a criterion for delaying the required diagnostic assessment, providing the case manager time to establish a relationship with the person, and permitting the person to obtain needed services. See part 9505.0323, subpart 20 about the conditions under which a child may authorize mental health services. A child's parent sometimes refuses to authorize services for a child who has an emotional disturbance. This subitem is consistent with part 9505.0323, subpart 20 which states that "authorization by the child's parent or legal representative is not required if ... the parent or legal representative is hindering or impeding the child's access to mental health services."

Item C. This item is reasonable as there are other criteria besides the results of a diagnostic assessment that a case manager may use for inferring that an adult may have a serious and persistent mental illness or a child has a severe emotional disturbance. The criteria are derived from historical evidence and present data about the person's functioning in daily life, the person's behaviors which indicate that the person is at risk of harming self or others as a result of emotional disturbance, the person's record of hospitalization or residential treatment because of mental illness, or court commitment or stay of commitment because of the person's mental illness. See Minnesota Statutes, sections 245.462, subdivision 20, paragraph (c), which defines serious and persistent mental illness, and section 245.4871, subdivision 6, which defines severe emotional disturbance.

Item D. A diagnostic assessment not only determines whether an adult meets the criterion of serious and persistent mental illness or a child meets the crierion of severe emotional disturbance but it also identifies the mental health services needed by the adult or child. See Minnesota Statutes, sections 245.462, subdivision 9 and 245.4871, subdivision 11. The case manager needs this information to properly prepare the adult's individual community support plan or the child's individual family community support plan. The case manager also needs the information to help the person gain access to all necessary services. As discussed in the SNR of part 9505.0323, subpart 2, a recipient's mental health status may change so that the recipient no longer needs the same level of mental health services specified in the recipient's diagnostic assessment. Thus it is necessary and reasonable to require the person to obtain a new or updated diagnostic assessment and to limit the time in which case management services may be provided before the new or updated diagnostic assessment is obtained. The Department established an advisory committee to assist the Department in implementing case management services under present parts 9505.0476 to 0491. The purpose of the committee was to discuss with the Department any problems encountered in providing case management services and recommend potential solutions to the problems. The committee consisting of county contracted case management providers, case managers, and advocates met six times during 1990. The committee recommended a limited period of eligibility for persons who refuse a diagnostic assessment during which the case manager has time to establish trust and rapport needed to encourage the person to obtain a diagnostic assessment. Under subpart 10, item A, a client may receive up to six hours of case management services per month or a total of 24 hours in a four month period. The client at risk because of the client's mental illness or emotional disturbance may receive additional hours as specified in item B of subpart 10. Thus a client at risk

may receive up to a total of 40 hours of case management services before a new or updated diagnostic assessment is required to determine the client's eligibility for case management. This limit was accepted as reasonable by the Advisory Committee; it is the same limit set in part 9505.0480, subpart 14, item D [Emergency].

Subp. 5. Determination of recipient's continued eligibility for case management services. Members of the advisory committee agreed that the mental health status of a person with a serious and persistent mental illness or a severe emotional disturbance most commonly is slow to change. The members of the advisory committe also agreed that persons determined eligible for case management services because of serious and persistent mental illness or severe emotional disturbance are less likely to recover fully from an episode of mental illness than persons with a less severe mental illness. For example the definition of serious and persistent mental illness in Minnesota Statutes, section 245.462, subdivison 20 includes criteria which reflect the legislators' attempt to identify the persons that are most seriously ill and least likely to recover. These criteria are in c (1) and (2) of subdivision 20 which state, respectively, that the adult has undergone two or more episodes of inpatient care for mental illness within the preceding 24 months or the adult has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration. Similar criteria are found in regard to children in Minnesota Statutes, section 245.4871, subdivision 6, which states in clause (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 an emotiional disturbance," and in clause (4), "the child, as a result of emotional disturbance, 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." Therefore, these adults and children will be likely to need case management services for an extended period. However, major advances in biological psychiatry are helping persons whose mental status was previously slow to change to respond more positively to treatment. The result is a shift from chronicity and more frequent reviews and updates of a diagnostic assessment are necessary to determine the client's present condition. The result of the change may be that the person may no longer have a serious and persistent mental illness or severe emotional disturbance and thus be ineligible for case management services. The changes may be such that the services identified in the person's most recent diagnostic assessment are no longer appropriate and necessary. Thus it is necessary to require a determination of the recipient's continued eligibility for case management services. It is reasonable to require either a complete diagnostic assessment or an updated diagnostic assessment for this purpose as the diagnostic assessment is the instrument that provides the needed information. Members of the advisory committee agreed that eighteen months is a reasonable interval before requiring a review and updating or a new diagnostic assessment because the nature of the illness of persons receiving case management services is inherently long term and slow to respond to treatment. See the SNR of part 9505.0323, subpart 2 which discusses the reasons a review and updating or a complete new diagnostic assessment are required annually for purposes of continued eligibility of a medical assistance eligible person for mental

health services other than case management services. Allowing a longer period of time between the diagnostic assessment of individuals receiving case management is reasonable because of the chronicity of serious and persistent mental illness and severe emotional disturbance. Furthermore, a recipient with serious and persistent mental illness or severe emotional disturbance has access on an ongoing basis to a case manager who by training and experience is able to help the recipient to gain access to needed mental health services, including a diagnostic assessment if the case manager believes the recipient's previous one needs to be reviewed and updated or replaced. By contrast, a person with a mental illness or emotional disturbance does not have the assistance of a case manager and may not recognize changes in his or her mental health status or service needs. Therefore, the difference between the two rule provisions, part 9505.0323, subpart 2 and part 9505.0322, subpart 5 is reasonable. Additionally, it is consistent with safeguarding against unnecessary use of medical assistance services and avoiding excess payments as required by Minnesota Statutes, section 256B.04, subdivision 15.

Subp. 6. Eligible provider of case management services. This subpart specifies the entities eligible to enroll under medical assistance as case management providers. A uniform standard is consistent with Minnesota Statutes, section 256B.04, subdivision 2. Limiting enrollment as a case management provider to a local agency or an entity under contract to the local agency to provide case management services is consistent with Minnesota Statutes, sections 245.462, subdivision 4 and 245.4871, subdivision 4 which require a case manager to be "an individual employed by the county or other entity authorized by the county to provide case management services....". The standard also is reasonable as it assists the county board to monitor the provision of the case management services and determine whether the services meet the obligations for service standards and quality placed on the county board in Minnesota Statutes, sections 245.465, subdivision 1, clause (3) and 245.467, subdivision 1, in the case of adults and sections 245.4874 and 245.4876 in the case of children.

Subp. 7. Condition to receive medical assistance payment; case manager qualifications. This subpart setting case manager qualifications is necessary to establish a uniform statewide standard as required under Minnesota Statutes, section 256B.04, subdivision 2. Minnesota Statutes, sections 245.462, subdivision 4, in the case of case management services to an adult, and 245.4871, subdivision 4, for services to a child, set forth the qualifications of a case manager. As set forth in Minnesota Statutes, section 245.462, subdivision 4, the case manager for an adult is expected to be skilled in the process of identifying a wide range of client needs, knowledgeable about community resources and how to use those resources for the benefit of the client. Similar expectations are set in Minnesota Statutes, section 245.4871, subdivision 4 about the case manager for a child. Therefore, specifying qualifications is reasonable so that the child and adult will receive case management services from a person who meets at least the minimum qualifications of knowledge and skills to provide the case management services needed by the person. This subpart also is reasonable as it is consistent with and reflects the standards enacted by the legislature. See also present part 9505.0484, subpart 1 and proposed part 9520.0912, subparts 1

and 2 and the SNR of the proposed part.

Subp. 8. Condition to receive medical assistance payment; clinical supervision required. This subpart is necessary to establish a uniform statewide standard as required under Minnesota Statutes, section 256B.04, subdivision 2. Requiring clinical supervision of case managers is consistent with the requirements stated in Minnesota Statutes, sections 245.462, subdivision 4 for case management services to an adult, and 245.4871, subdivision 4 for services to a child. The standard of clinical supervision required is reasonable as it reflects the prevailing thinking of the legislature. Additionally clinical supervision is reasonable as it benefits both the client and the case manager who is supervised. Through the clincal supervision by a mental health professional who has had a more rigorous training and longer experience than the case manager who is a mental health practitioner, the case manager has the opportunity to increase his or her knowledge and skills. The mental health professional's clinical supervision benefits the client by assuring that the case manager has properly identifed the services and resources needed by the client, has developed an appropriate individual community support plan or individual family community support plan for the client and when necessary by making recommendations about the client's services and plan. Thus, the client receives direct case management services from the mental health practitioner and indirect case management services from the mental health professional who is the clinical supervisor. Also see present part 9505.0484, subpart 2 and proposed part 9520.0912, subpart 3 and the SNR of the proposed part.

Subp. 9. Case management services eligible for medical assistance. This subpart is necessary to set a uniform standard of services that are eligible for medical assistance payment as case management services. A uniform standard is required by Minnesota Statutes, section 256B.04, subdivision 2. Items A to G are contacts that are necessary to carry out the activities included in the definition of case management activities in Minnesota Statutes, sections 245.462, subdivision 3 and 245.4871, subdivision 3. To coordinate the services of a client and help a client gain access to needed medical, social, educational, vocational, and other services a case manager must talk to the client to determine the client's needed services. The case manager also may have to talk to potential providers of the needed services including other case management services. This communication is necessary to gather information about the client and the client's needs and to discuss with potential and current providers the client's service needs and progress in meeting the goals in the client's individual community support plan. The case manager also must gather the data needed to complete the client's functional assessment. Gathering the data requires contact with the client and persons authorized by the client to share client information. The case manager may have to travel to the client's location if, for example, the client resides outside the county. Thus it is reasonable to pay for these contacts as they are necessary for the case manager to gather the required information and carry out his or her case management responsibilities to the client. It also is reasonable to permit the case manager to gather the information through telephone contacts. Using the telephone is a cost effective and efficient method of gathering data as compared to traveling to the person's location.

The Department notes that these activities including telephone contacts have been approved by the Health Care Financing Administration for federal financial participation. See Minnesota Statutes, section 256B.04, subdivision 4 which requires the Department to cooperate with the federal government in any reasonable manner necessary to obtain federal financial particpation. Items A to G are found in present part 9505.0491, subpart 2 [Emergency]. It should be noted that the emergency amendment to part 9505.0491 retained items A to F and added item G. The provisions of item G are necessary to meet the requirement of Minnesota Statutes 1991, section 245.4711, subdivision 9, (a)(5). Therefore, it is reasonable to provide payment for time spent performing these activities.

According to members of the advisory committee, the probability of some clients with serious and persistent mental illness or severe emotional disturbance failing to keep scheduled appointments or failing to wait if a case manager is late for the scheduled appointment is high as these clients may have an unstable day-to-day living status resulting from their unstable mental status. The client's failure to keep the appointment should not be used to deny payment to the case manager who has incurred the burden and expense of traveling to meet the client and in doing so is not available to serve other clients and to receive payment for such services. Thus it is reasonable to provide payment for time spent traveling under items F and G to meet face-to-face with a client if the client fails to keep the scheduled appointment. It also is reasonable to limit payment for missed appointments to the circumstance in which the case manager arrives on time for the scheduled appointment. Timeliness is expected of employees and persons under contract to perform services. Moreover, it would be unreasonable to pay for a case manager's services if the client arrives in time for the appointment and, because the case manager is late, the client leaves before the case manager arrives. Under this circumstance, the case manager has not carried out his or her responsibility to meet the client at the appointed time.

Subp. 10. Limitation on payments for services. Minnesota Statutes, section 256B.04, subdivision 12 requires the commissioner to place limits on the types and frequency of services covered by medical assistance. This part is necessary to establish the required limits. The Department calls attention to the fact that a case manager under present parts 9505.0476 to 9505.0491 and proposed parts 9505.0322 and 9520.0900 to 9520.0926 does not have the authority to require a client to use case management services in order to access a mental health service provider. The case manager under these parts coordinates, links, and monitors. Therefore the case manager under present parts 9505.0476 to 9505.0491 and proposed parts 9505.0322 and 9520.0900 to 9520.0926 has functions that are of a more limited scope and authority than a case manager under parts 9525.0015 to 9525.165 which require the authorization of the county board on the recommendation of the case manager before a service may be provided to a person with mental retardation or a related condition. Thus the Department believes that a case manager providing services to persons with serious and persistent mental illness or with severe emotional disturbance will need less time to perform case management services under proposed part 9505.0322 than does a case manager under parts 9525.0015 to 9525.0165. The Department also calls attention to the fact that persons with mental retardation or related conditions who have serious and persistent mental illness or severe emotional disturbance and who are receiving case

management services under parts 9525.0015 to 9525.0165 as services authorized under the waiver granted by the United State Department of Health and Human Services are exempt from the provisions of parts 9520.0900 to 9520.0926 and will continue to receive case management services under parts 9525.0015 to 9525.0165. (See proposed part 9520.0923, subpart 2.)

Item A. This item continues the limit set forth in part 9505.0491, subpart 3, item A as adopted in 1988. It should be noted that item A was not amended in the emergency rules which were effective December 27, 1991. Possible changes were discussed with members of the Rule Advisory Committee but the committee agreed with the Department that the number of hours is sufficient, especially given the greater number available to recipients at risk as specified in item B.

Item B. This item continues the limit set forth in part 9505.0491, subpart 3 item B as adopted in 1988. It should be noted that item B was not amended in the emergency rules which were effective December 27, 1991. The exception in the present rule recognizes that certain clients require more case management services than others. Some child clients also will require more case management services than adult clients. Therefore, proposed item B expands the circumstances that place a client "at risk" to include the additional circumstances that may place a child at risk. These circumstances include being subjected to abuse or neglect and failing or dropping out of school before completing the requirements of the program in which the recipient is enrolled. Therefore, it is necessary and reasonable to provide an exception from the limits in item A so these children may receive the case management services necessary to address their "at risk" status. In the opinion of Department staff who are experts in the area of services to children with severe emotional disturbance, defining "at risk" to include these circumstances is reasonable because it identifies circumstances that impede the functioning of children with severe emotional disturbance. See Minnesota Statues, section 245.487, subdivision 3 which includes within the mission of the children's mental health service system the provision of services that "address the unique physical, emotional, social, and educational needs of children" and "are appropriate to the developmental needs of children". The expansion is reasonable as it is consistent with the mission established for the system by the Legislature. Finally, allowing additional hours of case management services to a child, if prior authorization is obtained, is reasonable because it recognizes that additional time may be needed in the case of a child for the case manager to work with the child's parents and representatives of other agencies, such as schools and the county's Child Protection Unit, which provide services to children. The Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services has stated that the prior authorization requirement can be used to limit the scope, duration and amount of a medically necessary service provided to a child who is receiving Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services. See 42 USCA 1396d(r) which establishes medical necessity as the criterion for controlling the use of EPSDT services and Minnesota Statutes, section 256B.04, subdivision 15 which requires the Department to safeguard against unnecessary services. See also Chicago Regional State Letter No. 75-91, which states "among the methods a State may employ [under EPSDT] to safeguard against unnecessary utilization of care and services is a system of prior approval." (See attachment 2.) Prior

authorization is the means used by the Department to safeguard against the unnecessary and inappropriate use of medical assistance. A recipient who is a child is eligible for EPSDT services. If the EPSDT screening identifies the eligible child as having a severe emotional disturbance, the child may receive case management services under this part and medically necessary home-based mental health services under proposed part 9505.0324. Thus the prior authorization requirement is a reasonable limitation as it is consistent with information from HCFA about limitations on services to children with severe emotional disturbance and with other rules of the medical assistance program. See also proposed part 9520.0916 which relates to the case management team for a child with severe emotional disturbance.

Items C to E. These items are consistent with Minnesota Statutes, section 256B.04, subdivision 15 which requires the Department to avoid duplication of payment and to safeguard against excess medical assistance payments. Item C which limits the case manager to one payment for a period spent with the client is reasonable as it assures the case manager of being paid for the time spent but also safeguards against a duplicate billing for the same time: the case manager may choose whether the billing is for a face to face session or for the time spent traveling with the client. Item D prohibits payment for an assessment that is eligible for payment under subpart 2 or 5. The payment rate for such an assessment includes payment for the case manager's time and work. Therefore, an additional payment would be a duplicate payment. Item E is consistent with the prohibition of payment for concurrent care set forth in part 9505.0220, item M.

Item F. This item continues language in present part 9505.0491, subpart 5 [Emergency]. It also continues the medical assistance payment ineligibility of charting and recordkeeping set forth in part 9505.0491, subpart 5 as originally adopted. It is reasonable to exclude these activities from eligibility for payment as these activities do not provide a direct service to the case manager's clients but are administrative functions. It also should be noted that the medical assistance payment rate for case management services does include a factor for the time spent in these activities. See the attached Statement of Need and Reasonablenss presented by the Department in support of 9505.0491, subpart 7, which sets the statewide payment amount for case management services.

Item G. To be eligible for medical assistance payment, case management services must be provided to the recipient and must meet the other requirements of part 9505.0322. A case manager who is not providing a case management service eligible for medical assistance while in court cannot reasonably expect to be paid for a case management services because he or she is not providing a case management service. Medical assistance payment is limited to services that are actually provided. It would be unreasonable and inconsistent with the requirement of Minnesota Statutes, section 256B.04, subdivison 15 to use medical assistance to pay for a case manager's time under such a circumstance.

Item H. Prohibiting medical assistance payment for time spent in communication with other case managers who are members of the recipient's case management team if the recipient is not there is reasonable because no service is being given directly to the client and the case manager's payment rate includes a factor for this type of communication. Item H is reasonable as it prevents possible duplication of payment for services as required by Minnesota

Statutes, section 256B.04, subdivision 15.

Subp. 11. Documentation of services. This subpart is necessary to set a standard for records of services provided by the case manager to recipients. A standard is necessary and reasonable to comply with the requirement of Minnesota Statutes, section 256B.04, subdivision 2 of administering the medical assistance program statewide in a uniform manner. Case management services are mental health services. Part 9505.0323, subpart 26 specifies the documentation required to receive medical assistance payment for mental health services. Therefore, it is reasonable to specify that records about case management services follow the standard applicable to records of other mental health services as a single standard avoids confusion and is administratively efficient. See also parts 9505.2175 and 9505.2180 which set the standards for health service records required for surveillance and utilization review of medical assistance services. See also the State Medicaid Manual, section 4302.2L. (See Attachment 3.)

Subp. 12. Recovery of payment. This subpart continues a provision found in present part 9505.0491, subpart 10. (The Department notes that parts 9505.1750 to 9505.2150 were repealed as of the effective date of their successor parts 9505.2160 to 9505.2245.) Proposed subpart 12 is necessary and reasonable because it is consistent with part 9505.2215, subpart 1 which authorizes recovery of payment for failing to maintain health services records required under part 9505.2175. Also see the definition of "abuse" in part 9505.2165, subpart 2, item A (7). Additionally the provision is reasonable as it informs affected persons of the consequences of failure to comply with the documentation requirements. See Minnesota Statutes, section 256B.064, subdivision 1a which authorizes the commissioner to seek monetary recovery under certain circumstances.

Subp. 13. Excluded service. Client outreach is a community support service to adults with serious and persistent mental illness under Minnesota Statutes, section 245.462, subdivision 6 (1) and a family community support service to children with severe emotional disturbance and their families under Minnesota Statutes, section 245.4871, subdivision 17. The State Medicaid Manual, a federal document prepared by the Health Care Financing Administration (HCFA) as an interpretation of how the state is to operate its medical assistance program, states in section 4302.2 G2 that client outreach is not part of targeted case management and therefore is not eligible for medical assistance payment as a case management service. (See Attachment 3.) Therefore, this item is reasonable because it complies with a federal requirement and thereby complies with Minnesota Statutes, 256B.04, subdivision 4 which requires the state to cooperate with the federal government in any reasonable manner necessary to obtain federal financial pariticpation.

Subp. 14. Coordination of case management services with other programs. This subpart continues without substantive change a present permanent rule, part 9505.0479. The changes in proposed subpart 14 are technical. They replace the designation of subparts by items, amend the word "person" to "recipient", replace the term "the county" with the rule parts applicable to case management service, parts 9520.0900 to 9520.0926, and, in proposed item E,

revise the language of subpart 4 of part 9505.0479 to reflect the statute authorizing prepaid health plans for certain recipients. (See Attachment 4 , sections 801.01 and 801.05 of the MA/GAMC Provider Manual, which specify that a recipient with serious and persistent mental illness who is enrolled in a prepaid health plan is eligible for mental health case management on a fee for services basis.) Placing this material in subpart 14 of part 9505.0322 is reasonable as it clarifies its relation to medical assistance requirements which, under Minnesota Statutes, section 256B.04, subpart 15, prohibit duplicate payments for the same services. Persons specified in items A to D already receive case management services that are funded from sources other than medical assistance. These case management services are similar to those set forth in part 9505.0322. Thus this subpart is necessary and reasonable as it assures public funds will not be used to pay for duplicate services.

Background of amendments to part 9505.0323, Mental Health Services

Minnesota Rules, part 9505.0323 establishing eligibility to receive medical assistance payment as a provider of mental health services became effective January 1, 1990. The standards set forth in part 9505.0323 were those then in effect under the Minnesota comprehensive adult mental health act found in Minnesota Statutes, sections 245.461 to 245.486 and under the Medical Assistance Program, found in Minnesota Statutes, Chapter 256B as well as Title 42, Code of Federal Regulations. The Department notes that, because part 9505.0323 has not been revised since the Minnesota comprehensive children's mental health act, sections 245.487 to 245.4888 became effective, part 9505.0323 needs to be amended to assure consistency with sections 245.478 to 245.4888. The Legislature has further amended the Minnesota comprehensive mental health act, Minnesota Statutes, sections 245.461 to 245.4888 several times. The proposed amendments to part 9505.0323, if adopted, will reflect the statutory provisions enacted since the part's effective date of January 1, 1990.

9505.0323 MENTAL HEALTH SERVICES

Subpart 1. Definitions.

Item B. "Case management services" a term used in this part and part 9505.0322 are eligible for medical assistance payment. A definition is necessary to clarify the meaning. The definitions are reasonable because they inform affected persons where to find the statutory definitions applicable to case management services to adults and to children. See Minnesota Statutes, section 245.462, subdivision 3 in the case of an adult and section 245.4871, subdivision 3 in the case of a child. The Department has chosen to adopt statutory definitions because the definitions reflect the Legislature's prevailing thinking about the meaning of the term, which the Department is bound to follow.

Item C. "Case manager" is a term used in this part and part 9505.0322. A definition is necessary to clarify the meaning. The definitions are reasonable because they inform affected persons where to find the statutory definitions applicable to case management services to adults and to children. Citing the statutes which define the term is reasonable as they reflect the Legislature's prevailing thinking about the meaning of the term. The definition also is reasonable as it adopts the requirements the statutes have mandated. See Minnesota Statutes, section 245.462, subdivision 4 in the case of an adult and section 245.4871, subdivision 4 in the case of a child.

Items D, F and G. These technical amendments are necessary because of the new items B and C and do not affect the definitions within the item.

Item E. In addition to the technical amendment of the item designation, the Department proposes an amendment of item E to clarify that the term "client" includes a recipient who is determined to be emotionally disturbed. The amendment is reasonable as it clarifies who is eligible for the services governed by this part.

Item H. A diagnostic assessment is used to determine if a person has a serious and persistent mental illness or a severe emotional disturbance and is therefore eligible to receive case management services under parts 9505.0322 and 9520.0900 to 9520.0926. See Minnesota Statutes, section 245.4711,

subdivision 2, in regard to adults and section 245.4871, subdivision 11 in regard to children. See subpart 3 which requires the use of diagnostic assessment to determine a person's eligibility for mental health services under this part. Because diagnostic assessment is defined by reference to part 9505.0477, subpart 10 which will be repealed if parts 9520.0900 to 9520.0926 are adopted, it is necessary and reasonable to amend the definition in item F. The definition is the same as that set forth in Minnesota Statutes, section 245.4871, subdivision 11, in the case of a child, and similar to the one in Minnesota Statutes, section 245.462, subdivision 9, in the case of an adult.

Item I. A definition of "emotional disturbance" is necessary to clarify its meaning. The definition is reasonable because it informs affected persons where to find the statutory definition applicable to a disorder experienced by some children. The definition is reasonable because it is consistent with Minnesota Statutes, section 245.4871, subdivision 15.

Item J. The relettering of this item is a technical change that does not affect the item's substance. Minnesota Statutes, section 245.4871, subdivision 33a defines a special mental health consultant as "a mental health practitioner or mental health professional with special expertise in treating children from a particular cultural or racial minority group." Minnesota Statutes, section 245.487, subdivision 3, clause (3)(iv) requires children's mental health services to be sensitive to cultural differences and special needs. Minnesota Statutes, section 245.4876, subdivision 1, clause (2) requires children's mental health services to be "based on individual...cultural, and ethnic needs, and other special needs of the child being served." An explanation of findings is carried out to explain information about the client and recommendations about services to the client. Both the person presenting the explanation of findings and the person receiving it must consider it in the context of the client's individual, cultural and ethnic needs, and other special needs. Therefore, it is reasonable to amend the definition by including within the definition consultation with a special mental health consultant because the consultation is consistent with the purpose of the explanation and the basis for children's mental health services in the statutes cited above.

Items K to O. These technical amendments are necessary because of the new items inserted above and do not affect the definitions within the item.

Item P. The relettering of this item is a technical change that does not affect the item's substance. This term is defined to differentiate it from an individual community support plan, a term which also is used in these rules. Because part 9505.0477, subpart 14 will be repealed if parts 9520.0900 to 9520.0926 are adopted, it is necessary and reasonable to amend the definition in item P. Citing the statutes which define the term for services to adults and to children is reasonable as it reflects the Legislature's prevailing thinking about the meaning of the term.

Item Q. The relettering of this item is a technical change that does not affect the item's substance. The additional technical amendment of this item is necessary to reflect two proposed parts establishing medical assistance standards for certain mental health services. The amendment is necessary and reasonable because it informs affected persons of the mental health services available to recipients who are mentally ill including home based mental health services to children up to age 21 under proposed part 9505.0324 and

mental health case management services to persons with serious and persistent mental illness or severe emotional disturbance under proposed part 9505.0322.
Item R. The relettering of this item is a technical change that does not affect the item's substance. As used in the rule, mental illness encompasses the full range of diagnostic codes applicable to mental illness including those which apply to persons with serious and persistent mental illness. Because part 9505.0477, subpart 20 will be repealed when parts 9520.0900 to 9520.0926 are adopted, it is necessary and reasonable to amend item R. Citing the statute which defines the term is reasonable as it reflects the Legislature's prevailing thinking about the meaning of the term.
Item S. This term appears in subpart 28 of this part and also in part 9505.0324. A definition is necessary to clarify its meaning. The definition is reasonable because it informs affected persons.
Items T and U. The relettering of these items is a technical change that does not affect the items' substance.
Item V. This definition is necessary to clarify an abbreviation used in this rule to identify a person other than a child's parent who cares for a child. The technical amendment deletes the reference to part 9505.0477, subpart 23. The deletion is reasonable because part 9505.0477, subpart 23 will be repealed when proposed parts 9520.0900 to 9520.0926 are adopted.
Items W to Y. The relettering of these items is a technical change that does not affect the items' substance.
Item Z. "Special mental health consultant" is a term used in this part. It refers to a person who provides case management services to mental health practitioner or professional with special expertise in treating children from a particular coultural or racial minority group. Citing the statutes which define the term is reasonable as it reflects the Legislature's prevailing thinking about the meaning of the term.
Subp. 2. Determination of mental illness or emotional disturbance. This subpart sets forth the criterion and the means to be used as the basis for determining a recipient's eligibility for mental health services. The criterion of eligibility is mental illness or emotional disturbance. A diagnostic assessment is used to determine whether the person has a mental illness or an emotional disturbance. The diagnostic assessment also identifies the mental health services that are medically necessary for the recipient as a result of the recipient's mental illness or emotional disturbance. According to members of the advisory committee, a recipient's mental health status may change so that the same level or type of mental health services specified in the recipient's previous diagnostic assessment is not medically necessary and appropriate for the recipient. The recipient may need fewer or less intensive services, or additional or more intensive mental health services. Thus it is reasonable to require a review of the recipient's diagnostic assessment to determine the recipient's continued need for and appropriateness of services. Federal regulations at 42 USC 1396 permit the state to establish limits on the frequency of services based on medical necessity. Thus, the state may establish its own requirement for reviewing and updating a diagnostic assessment. Members of the subcommittee discussed the timing of the required review of the diagnostic diagnostic assessment. They stated that for clients such as those receiving case management services from a case manager a mandatory review every 18 months is appropriate because the case manager in providing case management services has the opportunity

through client contact of evaluating whether the client's mental status requires a more frequent review. They further stated that for persons who were not receiving case management services a mandatory review every 12 months was appropriate as the tendency of many persons to contact a mental health service provider at irregular intervals did not provide a regular, ongoing opportunity to evaluate the persons' mental health status. Therefore, the Department has reasonably chosen to use the standard of 12 months for a recipient who is receiving mental health services other than case management. See part 9505.0322, subpart 5 and its SNR. Additionally, members of the advisory committee agreed that the mental health status of a person with serious and persistent mental illness or with severe emotional disturbance more often than not remains the same over a long period of time. Thus, the case management model assumes the person's need for services because of a serious and persistent mental illness or a severe emotional disturbance will be long-term. In contrast a person with a mental illness or emotional disturbance of a lesser severity may need services that are more intensive than case management but that are necessary and appropriate for only a short time. Thus the shorter time between reviews and updatings is reasonable as it reflects the difference in the nature of the services and the types of mental illness or emotional disturbance. Finally the Department notes that a change in a recipient's behavior is included within the phrase "a change in the recipient's mental health condition".

Subp. 4. Eligibility for payment; diagnostic assessment. The proposed amendment of this subpart is technical for the purpose of deleting obsolete language. The current rule language was adopted before mental health professionals other than psychiatrists and psychologists became eligible to be medical assistance providers and to provide mental health services without clinical supervision.

Subp. 4, item I (6). This amendment clarifies the circumstances requiring a recipient's referral for services. A diagnostic assessment may be conducted by a person whose licensed scope of practice does not include medical services such as the determination of the need for and evaluation of the effectiveness of prescribed medication. For example, these functions are not within the scope of practice of a mental health professional who is a licensed independent clinical social worker or who is a registered nurse certified as a clinical specialist in psychiatric or mental health nursing. Furthermore, a psychiatrist is the only mental health professional qualified by licensure to diagnose medical conditions such as diabetes and tumors that may affect a recipient's mental status. Therefore, if there has not been an initial psychiatric consultation or medical evaluation, it is reasonable to require a referral for a psychiatric consultation and for medication evaluation because the psychiatric consultation and medication evaluation are activities necessary to obtain a complete evaluation of the person's mental health problems and the services needed to address those problems. See Minnesota Statutes, sections 245.462, subdivision 9 and 245.4871, subdivision 11 and subpart 1, item F for definitions of diagnostic assessment. Because a recipient's mental health status or response to medication may vary from time to time, the recipient's mental health services may need to be adjusted. Therefore, it is reasonable to require an updated consultation or reevaluation

of the recipient's need for medication so that the recipient's services continue to be necessary and appropriate to the recipient's condition. It also is reasonable because it maximizes the possibility of the recipient's benefit from psychotherapy and other mental health services.

Subp 22. Eligible vendors of mental health service before September 1, 1990. This amendment is of a technical nature to delete an obsolete requirement. See Minnesota Statutes, sections 245.462, subdivision 18 and 245.4871, subdivision 27 for the definition of mental health professional and Minnesota Statutes, sections 245.462, subdivision 4a and 245.4871, subdivision 7 for the definition of clinical supervision. Also see Minnesota Statutes, section 245.462, subdivision 21 and section 245.4871, subdivision 29 which specify that outpatient [mental health] services are to be "..provided by or under the supervision of a mental health professional...". See also subpart 31 which specifies the exception to this requirement.

Subp. 23. Medical assistance payment for mental health services; required personnel. The amendments to this subpart are necessary to delete obsolete language, improve the grammatical construction, and recognize the exceptions to the requirement that mental health services be provided by mental health professionals as a condition of eligibility to receive medical assistance payment. These exceptions are consistent with the provisions of Minnesota Statutes, sections 245.462, subdivision 19 and 245.4871, subdivision 28 which include case management services within the definition of mental health service; with Minnesota Statutes, sections 245.462, subdivision 4 and 245.4871, subdivision 4 which define case manager; with Minnesota Statutes, sections 245.462, subdivision 3 and 245.4871, subdivision 3 which specify who is to provide case management services; with Laws of Minnesota 1990, Chapter 568, Article 3, Section 97 (services under subpart 31); and with Minnesota Statutes, section 245.4884 subdivision 3(b) which requires [home-based mental health services] to children with severe emotional disturbance to be provided by a "..team consisting of a mental health professional and others who are skilled in the delivery of services to children and their families...". A mental health practitioner under the clinical supervision of a mental health professional may provide independent, group and family skills training as a component of home-based mental health services eligible for medical assistance payment. See part 9505.0324, subpart 6, item F. A mental health practitioner under clinical supervision also may provide case management services as covered services. See part 9505.0322, subpart 8. Additionally a mental health practitioner may participate as a member of the multidisciplinary team under clinical supervision of a mental health professional in the provision of day treatment and partial hospitalization. See 9505.0323, subpart 1, item G (former item E) and item U (former item Q), in regard to day treatment. The amendment of this subpart is necessary and reasonable to assure consistency among the various rules related to mental health services that are covered services and thus to avoid the possibility of conflict and misinterpretation of the medical assistance rules related to mental health services, parts 9505.0322 to 9505.0324.

Subp. 27. Excluded services.

Item D. This proposed amendment is technical for the purpose of deleting an outdated provision.

Subp. 29. Required participation of psychiatrist in treatment of person with serious and persistent mental illness or child with severe emotional disturbance. The proposed amendment to this subpart requires the participation of a psychiatrist or another qualified provider in certain mental health services to children with severe emotional disturbance. The services are the diagnostic assessment, formulation of an individual treatment plan, and monitoring of the child's clinical progress.

Item A requires a psychiatrist's participation if the client with a serious and persistent mental illness is under the care of a psychiatrist and receiving anti-psychotic or anti-depressant medication. The psychiatrist who provides such care to the person specified in this item has information about the person's mental health status and response to medication that is a part of the information needed to complete a diagnostic assessment, formulate the client's individual treatment plan, and monitor the client's progress. Accurate and effective completion of these activities depends upon full and complete information about the client's mental health status. Therefore it is reasonable to require the psychiatrist's participation because the participation is a way to obtain the needed information.

Item B specifies the circumstance under which such participation in a child's services is required. A mental health professional providing mental health services may be a person whose licensed scope of practice does not include medical services such as the determination of the need for and evaluation of the effectiveness of prescribed medication. For example, these functions are not within the scope of practice of a mental health professional who is a licensed independent clinical social worker or a registered nurse who is certified as a clinical specialist in psychiatric or mental health nursing; these functions are to be provided by a person licensed as a physician. Among licensed physicians are those recognized as specialists through further training and experience in providing services to children with severe emotional disturbance. These specialists include child psychiatrists, neurologists, and behavioral pediatricians. Thus proposed item B is reasonable as it reflects a standard of medical practice recognized by the respective specialty boards of medicine in the case of neurology and psychiatry and by the establishment of fellowships in behavioral pediatrics programs at accredited colleges of medicine. The standard assures that the condition and treatment of a child with severe emotional disturbance will involve the participation of an appropriately qualified medical practitioner. See subpart 4, item I (6) which requires a mental health professional conducting a diagnostic assessment to refer the recipient for psychiatric consultation and medication evaluation.

It should be noted that the Department is aware of the very limited availability of child psychiatrists. Information culled as of April 1992 from a survey of 470 Minnesota psychiatrists conducted by the Minnesota Psychiatric Society shows only 51 of the 274 respondents reported that they accept child patients. Furthermore, all except 2 or 3 of these 51 psychiatrists were located in the metropolitan area, Rochester, or Duluth. Thus, the Department believes that a significant proportion of the present population of children with severe emotional disturbance is being followed by behavioral

pediatricians and child neurologists for conditions that do not require the administration of anti-psychotic or anti-depressant medications. The Department believes that the administration and monitoring of anti-psychotics and antidepressants should remain exclusively in the scope of practice of a board certified psychiatrist. However, based on comments received during rule development from the Advisory Committee and in physicians' letters about the proposed amendment the Department has concluded that a community standard exists for children with severe emotional disturbance who do not require anti-psychotic or anti-depressant medication, but who need other kinds of psychoactive medication, to be followed by child neurologists, behavioral pediatricians, or psychiatrists. Due to the extreme shortage of child psychiatrists, as mentioned above, and because a community standard already exists to permit physicians with pediatric training in a field other than psychiatry to care for children with severe emotional disturbance, it is reasonable to permit their participation to assure children receive needed and appropriate services if they are being followed for the need for and effectiveness of psychoactive medication.
The other language amendments within this subpart are technical for purposes of clarity and grammatical construction and do not affect the substance.

Subp. 32. Coordination of services. This subpart is necessary to establish a requirement about coordination of mental health services if a recipient receives mental health services from more than one provider. For example, members of the advisory committee said that it is possible that a child with severe emotional disturbance might receive home-base mental health services under part 9505.0324 including individual skills training, case management services from a case manager, and concurrently receive day treatment services from another provider, medication monitoring from a child neurologist or behavioral pediatrician, and family or group psychotherapy from a mental health professional. Without coordination, these services may be fragmented or duplicative; or they may be antagonistic or interact in a manner that confuses or otherwise adversely affects the child. Coordination of mental health services is consistent with the creation of a unified, accountable, comprehensive adult mental health system as required under Minnesota Statutes, section 245.461, subdivision 2 and the coordination required under Minnesota Statutes, section 245.467, subdivision 1, clause (7). Coordination of services is consistent with the creation of a unified, accountable, comprehensive children's mental health service system as required under Minnesota Statutes, section 245.487, subdivision 3 and the coordination of services required under clause (3)(iii) of subdivision 3 and section 245.4876, subdivision 1, clause (9). Additionally coordination of services is a reasonable method of safeguarding against unnecessary and duplicate services as required by Minnesota Statutes, section 256B.04, subdivision 15. See proposed parts 9520.0900 to 9520.0926 and 9505.0322 which require a case manager to coordinate mental health services to a client.

9505.0324 HOME-BASED MENTAL HEALTH SERVICES

Background
Minnesota Statutes, section 245.4884, subdivision 3 states,

> [a county board] must provide or contract for sufficient professional

home-based family treatment .... to meet the needs of each child with severe emotional disturbance who is at risk of out-of-home placement due to the child's emotional disturbance or who is returning to the home from out-of-home placement.

Minnesota Statutes, section 245.484 requires the Department to adopt permanent rules to implement the provision of professional home-based family treatment services for medical assistance eligible children by January 1, 1993. Part 9505.0324 when adopted will replace the emergency rules related to home-based mental health services which became effective December 27, 1991.

In developing the emergency rule required under Minnesota Statutes, section 245.484, the Department had to consider the requirements of Title 42, Code of Federal Regulations, section 440.240 (b) (42 CFR 440.240 (b).) 42 CFR 440.240 (b) requires that if the state Medicaid plan provides an optional service to a categorically or medically needy group of individuals, the service must be available to all individuals in the group. These services must be equal in amount, duration and scope for to all individuals within the group in order to ensure equal protection to all similarly situated individuals.

Minnesota Statutes, section 245.4871, subdivision 31 defines home-based mental health services as "intensive mental health services provided to children because of an emotional disturbance (1) who are risk of out-of-home placement; (2) who are in out-of-home placement; or (3) who are returning from out-of-home placement." Such children comprise a group whose members are eligible for the covered service, home-based mental health services. Proposed part 9505.0324 establishes home-based mental health services as a component of the early periodic screening, diagnosis, and treatment (EPSDT) program which federal regulations at 42 CFR 440.40 (b) define as "screening and diagnostic services to determine physical or mental defects in recipients under age 21" and "health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered." Although Minnesota Statutes, section 245.4871, subdivision 5, a part of the Minnesota comprehensive children's mental health act, defines a child as a person under 18 years of age, the Department has chosen in accordance with its State Medicaid Plan to provide medical assistance coverage not only for persons under age 18 who have severe emotional disturbance but also for persons who are at least 18 years of age but less than 21 years of age and who have serious and persistent mental illness. See 42 CFR 440.130 which defines for medical assistance purposes the diagnostic services, screening services, and preventive services that may be covered under the State Medicaid Plan. The Department can find no rational basis to differentiate between these two age groups comprised of needy children and adolescents who have similar mental health conditions and are at risk of institutional or other out-of-home placement, or who are returning from an out-of-home placement, because of their mental health condition and who require diagnostic, screening, and preventive services as defined in 42 CFR 440.130. Also see 42 CFR 441.56 (2)(iii) which permits the State to choose to provide services to persons 18 years of age or older.

Specifying that home-based mental health services are services available under EPSDT to persons under age 21 is consistent with Minnesota Statutes, section 256B.04, subdivision 4 which requires the Department to cooperate with the federal government "in any reasonable manner as may be necessary to qualify for federal aid in connection with the medical assistance program...". See also Minnesota Statutes, section 256B.0625, subdivision 14 about medical assistance coverage of diagnostic, screening, and preventive services and

section 256B.0625, subdivision 24 about medical assistance coverage of other medical or remedial care licensed or recognized under state law.

Except where specifically noted, the proposed rule provisions which follow are the same as those in the emergency rules. The Department was assisted by a rule advisory committee in developing the emergency rules; the committee was reconvened and met once to assist in developing the proposed permanent rule. See attachment xxx for list of advisory committee members.

Subpart 1. Definitions. This subpart is necessary to clarify the meaning of terms used in part 9505.0324.

Item A. This item defines the term "child". A definition is necessary to clarify its meaning. The Minnesota children's comprehensive mental health act defines "child" as a person under 18 years of age. See Minnesota Statutes, section 245.4871, subdivision 5. Minnesota Statutes, section 256B.055, subdivision 9 authorizes "medical assistance ...for a person who is under 21 years of age and in need of medical care that neither the person nor the person's relatives ...are financially able to provide." See also Minnesota Statutes, section 256B.0625, subdivision 14 which authorizes medical assistance coverage of diagnostic, screening, and preventive services and subdivision 24 which authorizes medical assistance coverage of "any other medical or remedial care licensed and recognized under state unless prohibited by law...". See the discussion in the preceding section, Background. The definition is reasonable as it is consistent with the above cited state statutes. Defining child as a recipient under age 21 is reasonable because the option of providing EPSDT services including home based mental health services to persons under age 21 is available to the State under its State Medicaid Plan. It also is reasonable as it enables the Department to obtain federal financial participation in paying for the cost of the home-based mental health services needed by children under age 21 as required under Minnesota Statutes, section 256B.04, subdivision 4.

Item B. Minnesota Statutes, section 245.4871, subdivision 6 defines the term "child with severe emotional disturbance". Subdivision 6 of section 245.4871 must also be read in conjunction with subdivision 15 of section 245.4871, which defines "emotional disturbance" in children. Using the definition of child with severe emotional disturbance without modification would limit those eligible for home-based mental health services to persons under age 18 who have a severe emotional disturbance. As discussed above under Background and item A, part 9505.0324 applies to medical assistance recipients up to age 21. Thus it is also necessary to set forth in this subpart the term for the comparable organic disorder in persons aged 18 to 21 years as set forth under state law. See Minnesota Statutes, section 245.462, subdivision 20 which defines mental illness and serious and persistent mental illness in persons aged 18 to 21 years. The range of mental disorders specified in Minnesota Statutes, section 245.462, subdivision 20 is identical to that in Minnesota Statutes, section 245.4871, subdivision 15. Both statutes state, "[it is] an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that... is listed in the clinical manual of the International Classification of Diseases (ICD-9-CM), current edition, code range 290.0 to 302.99 or 306.0 to 316.0 or the

corresponding code in the American Psychiatric Associations's Diagnostic and Statistical Manual of Mental Disorders, (DSM-MD), current edition, Axes I, II, or III." The definition of adult with serious and persistent mental illness set forth in Minnesota Statutes, section 245.462, subdivision 20 and that of child with severe emotional disturbance in Minnesota Statutes, section 245.4871, subdivision 6 are also comparable as they include criteria about inpatient treatment or residential treatment for psychiatric care or an emotional disturbance. Both subdivision 6 and subdivision 20 have criteria about the individual's significantly impaired functioning and about the written opinion of a mental health professional that, in the case of a child, the individual as a result of an emotional disturbance has significantly impaired home, school, or community functioning that has lasted at least one year and that presents a substantial risk of lasting at least one year and that, in the case of an adult, the individual is reasonably likely to have future episodes requiring inpatient or residential treatment. Thus it is reasonable to extend the definition of child with severe emotional disturbance to include persons from ages 18 to 21 years who have serious and persistent mental illness as the range of diagnostic codes are identical and the other criteria are similar.

Item C. Defining the term "emotional disturbance" by reference to its definition in Minnesota Statutes, section 245.4871, subdivision 15 is reasonable because it assures consistency with law. Using this definition in part 9505.0324 without modification would limit those eligible for home-based mental health services to persons under age 18. As discussed in the SNR of item B above, the ranges of diagnostic codes related to mental illness and to emotional disturbance are identical. Therefore, it is reasonable to extend the definition of emotional disturbance to include persons at least age 18 but under age 21 as such persons belong to the same groups of categorically or medically needy persons as persons under age 18. Under 42 CFR 440.250 EPSDT services including home-based mental health services in proposed part 9505.0324 are not available to persons 21 years of age or older.

Item D. "Home-based mental health services" is a term used as a synonym throughout part 9505.0324 for the term "professional home-based family treatment" which is defined in Minnesota Statutes, section 245.4871, subdivision 31. Under Minnesota Statutes, section 245.4871, subdivision 31, the services are "intensive mental health services ... provided to the child and the child's family primarily in the child's home environment" and may also be provided in "the child's school, child care setting, or other community setting appropriate to the child." Using the term "home-based mental health services" is reasonable as it assists the reader to understand the scope of the available services and the setting where the service is to be provided. Also see the proposed definition in item F of this part which defines "residence" and its accompanying SNR. The definition in Item D requires the program to be "culturally appropriate." Minnesota Statutes, section 245.487, subdivision 3, clause (3)(v) requires a continuum of mental health system services that are "sensitive to cultural differences and special needs" of children. Minnesota Statutes, sections 245.467, subdivision 1, clause (2) and 245.4876, subdivision 1, clause (2) require mental health services to be based on the individual's cultural and ethnic needs. Therefore, requiring home-based mental health services to children up to age 21 to be a culturally appropriate program is reasonable as it is consistent with the criteria set in law for all

mental health services.
Minnesota Statutes, section 245.4884, subdivision 3 also sets forth requirements about eligibility for and the nature of the services. A child with an emotional disturbance or a severe emotional disturbance is not always at risk of out-of-home placement because of the emotional or severe emotional disturbance. For example, a child's mental status may be static and chronic. However, if the child's mental status becomes unstable and the child's emotional disturbance becomes acute, the child may temporarily experience an acute episode of emotional disturbance severe enough to be diagnosed as a severe emotional disturbance and to place the child at risk of out-of-home placement because the child's parents cannot reasonably be expected to have the skills necessary to treat the child. According to the literature, the intensity of mental health services available through home-based mental health services which provide both psychotherapy and individual, family, and group skills training is one of the more efficacious means of treating an acute episode of emotional disturbance. See the attached bibliography. With appropriate and necessary services, it may be possible to resolve the episode, meet the mental health needs of the child and the child's family, and provide the child and the child's family the skills needed so the child can remain at home. Thus specifying that the services are for the purposes of resolving an episode of emotional disturbance is consistent with the intent of Minnesota Statutes, section 245.4871, subdivision 31 and section 245.4884, subdivision 3.
Item E. This item is necessary to define a term used in this part. The definition is reasonable as it relies on Minnesota Statutes, section 245.4871, subdivision 21 which defines the term "individual treatment plan." Relying on the statutory definition assures consistency with the action of the legislature.
Item F. This definition is necessary to clarify the meaning of a term used in this part. The Department notes that this item is the same as the present emergency amendment to part 9505.0175, subpart 43. However, because of the definition's applicability only to part 9505.0324, the Department has chosen to place it in proposed permanent rule part 9505.0324.
A child with an emotional disturbance is admitted to an acute care hospital, regional treatment center, or residential treatment facility because of the child's immediate need for more intensive mental health services than otherwise would be available to the child. The residential treatment facility, acute care hospital, or regional treatment center care for a child on a 24-hour basis. The length of the child's stay depends on the child's need for services, the child's response to treatment, and the mental health services the child will need and be able to access in the community after discharge. The commonly held expectation is that the child will respond to treatment, be discharged, and return to his or her family. Thus even though the child's length of stay in treatment may not be certain at the time of the child's placement, there is no expectation that the child will use the treatment setting as a permanent dwelling place.
Part 9560.0510 states the purpose of foster care services to children is "to provide substitute family or group care for a child while an intensive effort is made to correct or improve the condition necessitating placement in order to reunite the family , or, in the failure of this, to provide some other permanent plan." Thus, the child is not expected to remain in a group home or

family foster care indefinitely. The definition is reasonable as it is consistent with the concept of the person's intent to continue to use a dwelling place indefinitely.
The definition also is consistent with the intent of Minnesota Statutes, section 245.4871 subdivision 31 that the services be family-oriented and provided on an individual family basis to the child and the child's family primarily in the child's home environment and with the intent of part 9505.0324, which is to set standards for the provision of mental health services in a child's home so the child at risk of institutionalization or out-of-home placement can remain at home. See Minnesota Statutes, section 245.4884, subdivision 3.
The care provided to a child with a severe emotional disturbance by an acute care hospital, regional treatment center or residential treatment facility includes at least some of the mental health services needed by the child. Payment for care in one of these entities includes payment for these mental health services. Thus, the amendment clarifying "residence" also is reasonable because it prevents duplication of payment under proposed part 9505.0324 in the case of a mental health service provided as part of an institution's or facility's program.

Subp. 2. Eligible providers of home-based mental health services. This subpart is necessary to set a uniform standard that providers must meet to receive medical assistance payment for home-based mental health services to recipients. A uniform standard is required by Minnesota Statutes, section 256B.04, subdivision 2.
In reviewing the types of entities that could potentially provide home-based mental health services, the Department used three criteria: 1. the entity has an interdisciplinary or multidisciplinary staff that has competencies in more than one area of mental health services and thus can provide a variety of therapies; 2. the entities are distributed widely enough throughout Minnesota that eligible children will have access to home-based mental health services; and 3. the entities have sufficient staff resources to provide 24 hour coverage. The first criterion is reasonable as the availability of a interdisciplinary or multidisciplinary staff assures a continuum of mental health services available to the child that address the unique needs of the child as required under Minnesota Statutes, section 245.487, subdivision 3, clause (3) (ii). See also Minnesota Statutes, section 245.4884, subdivision 3, paragraph (b) which requires home-based mental health services to 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 their families. The second criterion is reasonable because it is consistent with Minnesota Statutes, section 245.487, subdivision 3, clauses (2) and (3) which require the mental health system to make preventive services available to all children and assure access to a continuum of services. The third criterion is reasonable because Minnesota Statutes, section 245.4884, subdivision 3, paragraph (b) requires the home-based mental health treatment team to "provide or arrange for crisis services for each family, 24 hours a day, seven days a week."
The entities specified in items A and B as eligible providers have been investigated and determined to be in compliance with licensing or provider standards applicable to mental health services. The entity specified in item

C, although not licensed, has been reviewed and approved by the commissioner pursuant to Minnesota Statutes, sections 62A.152 and 245.69, subdivision 2 to receive insurance payments for the provision of mental health services. The approval or licensing procedures include a review of staffing patterns, staff qualifications, and clinical supervision. Thus, the Department has the information needed to determine that these entities are able to comply with the three criteria the Department has used in setting forth the a uniform provider standard.

See also subpart 5 and its SNR about additional provider standards.

Item D. Minnesota Statutes, section 245.4884, subdivision 3 requires a county board to provide or contract for sufficient home-based mental health services "within the county to meet the needs of each child with severe emotional disturbance" who is at risk as specified in subdivision 3. Therefore, specifying that the county board is an entity eligible to provide home-based mental health services is reasonable as it is consistent with subdivision 3. A county board may choose to contract for the required services rather than enroll as a medical assistance provider of home-based mental health services. See also Minnesota Statutes, section 245.488, subdivision 1 which permits outpatient services such as home-based mental health services to be provided directly by the county through county-operated mental health centers or mental health clinics approved by the commissioner under Minnesota Statutes, section 245.69, subdivision 2; or by contract with privately operated mental health centers approved by the commissioner under section 245.69, subdivision 2. Defining county board for purposes of this item is necessary to clarify its meaning. The definition is reasonable as it is the same as that in Minnesota Statutes, section 245.4871, subdivision 9, which defines county board for the purposes of the Comprehensive children's mental health act.

Item D specifies that a county board may only contract with an entity specified in Items A to C. Specifying the entity with whom the county board may contract for the required service is reasonable as a county board may not have access to the information available to the Department from which to determine whether an entity meets the service criteria mentioned above. The requirement also is reasonable because it assures a uniform standard of provider eligibility will be applied and at least a uniform minimum service standard will be available to all children who are eligible for home-based mental health services under part 9505.0324. If a county board chooses to contract for the required services, Item D requires the persons providing the services on behalf of the entity under contract to be the entity's employees. In proposing this requirement, the Department is setting forth a quality assurance mechanism so that the actual service providers will possess the professional qualifications set forth in the Minnesota comprehensive children's mental health act and part 9505.0324 and deliver the required services according to the Act and the standards of this part. An employee is accountable to his or her employer; the contracting entity whose employee provides the service is responsible to the county board for compliance with the contract terms. Thus, there is a clear line of responsibility from employee to employer under contract to county board. Requiring the person to be an employee of the county-board contracted provider is reasonable as it ensures the employer takes full responsibility for the employee's services and can be held accountable by the county board for those services. However, the Department has no assurance that a self-employed vendor or independent

contractor will meet the standards required by the county board and this part.

It is necessary to define "employee" to clarify its meaning and avoid confusion. Because 42 CFR 447.10 (d) limits eligibility for medical assistance payments to a person or entity that is a provider, it is reasonable to define the status of the provider's employee in terms of the provider's financial relationship to the employee. The American Heritage Dictionary of the English Language (New College Edition, 1978) defines "employee" as a "person who works for another in return for financial or other compensation." Thus the definition is reasonable because it is consistent with a commonly accepted standard for an employer-employee relationship. Further clarification of the employee-employer relationship is necessary because some persons who receive compensation from providers are independent contractors who, as self-employed persons, contract to provide certain services for the providers. State and federal laws do not require the withholding of taxes from payments made to such self-employed persons but do require withholding taxes from the compensation of employees. Thus the definition is reasonable as it distinguishes between employees and persons who are self-employed vendors or independent contractors.

Subp. 3. Eligibility to receive home-based mental health services. This subpart is necessary to specify the procedure for determining whether a child is eligible for home-based mental health services. Minnesota Statutes, section 245.4884, subdivision 3 states that home-based-mental health services are to be provided to certain children who have severe emotional disturbance. A standard procedure for determining whether a child has a severe emotional disturbance is necessary because it assists in administering the medical assistance program statewide in a uniform manner as required by Minnesota Statutes, section 256B.04, subdivision 2. A diagnostic assessment is a procedure for making such a determination. Minnesota Statutes, section 245.4871, subdivision 11 defines the term as an evaluation of the child's diagnosis including a determination of whether the child meets the criteria of severely emotionally disturbed. The definition of the diagnostic assessment of an adult set forth in Minnesota Statutes, section 245.462, subdivision 9 requires the assessment to provide a written summary of the adult's diagnosis and general service needs. Thus using a diagnostic assessment to determine a child's eligibility for home-based mental health services is reasonable as it is consistent with the purposes of a diagnostic assessment as set forth in the statutory definitions of the term. Additionally, it is a reasonable requirement because the diagnostic assessment provides evidence that enables the Department to determine whether the home-based mental health services are medically necessary and appropriate for the recipient as required under Minnesota Statutes, section 256B.04, subdivision 15. The Department notes that part 9505.0323, subpart 2 requires a diagnostic assessment to determine if a recipient is eligible to receive mental health services under medical assistance.
42 CFR 440.40 (b) defines EPSDT "screening and diagnostic services to determine...mental defects in recipients under age 21." See also title 42, United States Code, section 1396d(r) which defines screening services as services which include the determination of the existence of mental illnesses and include an assessment of mental health. As discussed in the preceding

paragraph, a diagnostic assessment is a screening procedure for determining the existence of mental illness in a child. Thus stating that a diagnostic assessment may be a service under EPSDT is reasonable because the service is consistent with federal laws and regulations applicable to the EPSDT program.

Subp. 4. Eligibility for medical assistance payment. This subpart is necessary to clarify the eligibility requirements applicable to all providers of home-based mental health services. Requiring the home-based mental health provider to assist a child's case manager, if any, in coordinating services to the children and their families is reasonable as the requirement meets the standard set forth in Minnesota Statutes, sections 245.467, subdivision 1, clause (7), 245.4876, subdivision 1, clause (9), and 245.4884, subdivision 3, paragraph (b).

Item A. Minnesota Statutes, section 245.4884, subdivision 3, paragraph (b) requires home-based mental health services to be provided by a team consisting of mental health professionals and others who are skilled in the delivery of mental health services to children and families. This item is reasonable as it is consistent with the requirement that home-based mental health services be provided by persons who are skilled in the delivery of mental health services to children. For the qualifications of a mental health practitioner, see Minnesota Statutes, section 245.4871, subdivision 26; for the qualifications of a mental health professional, see section 245.4871, subdivision 27. Both subdivisions 26 and 27 require training and experience in working with children as a qualification to provide mental health services to children with emotional disturbance. See the proposed amendment of part 9505.0175, subpart 27 which defines mental health practitioner and subpart 28 which defines mental health professional for purposes of the medical assistance program.

Item A also is consistent with part 9505.0323, subpart 23 and its proposed amendment which require mental health services to by provided by a mental health professional or a mental health practitioner as a condition to receive medical assistance payment.

Item B. This item is consistent with Minnesota Statutes, section 245.4884, subdivision 3, paragraph (b) which requires the treatment team providing home-based mental health services to develop an individual treatment plan that identifies the specific treatment objectives for both the child and the family. It is reasonable to require the services to be designed to meet the needs according to the plan because it assures that the services will be medically necessary for treatment of the child and the family.

Item C. This item is consistent with Minnesota Statutes, section 245.4884, subdivision 3 (b) which requires the provider to "maintain flexible hours of service availability and ..provide or..arrange for crisis services for each family, 24 hours a day, seven days a week."

Item D. Minnesota Statutes, section 245.4884, subdivision 3, paragraph (b) states, "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." This item is consistent with the statutory requirement. The Department believes that the home-based mental health service provider is in the best position to know the services needed by the eligible children and their families. Members of the rule advisory committee

reported that all mental health professionals have an inherent ethical obligation to the board granting their licensure or certification to exercise appropriate professional judgment in determining the number of clients that they can adequately and competently serve. The members reported that there are differences among their clients and the clients' families regarding the intensity and frequency of needed services and the time required to travel to the setting in which home-based mental health services are provided. Therefore, it would be unreasonable to set a caseload limit because the limit would not take into account the differences among the clients. The Department notes that item D paraphrases Minnesota Statutes, section 245.4884, subdivision 3, paragraph (b) which states, "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." Item D permits the compliance with this requirement.

Item E. This item is required under Minnesota Statutes, section 245.4884, subdivision 3 (b). Case management services to a child as defined in Minnesota Statutes, section 245.4871, subdivision 3, include the activity of assisting the child and the child's family in obtaining needed services through coordination with other agencies. Coordination of services is a means to assure continuity of services, avoid duplicate services and omission of needed services, and reduce the client's and provider's potential confusion about the client's services. It is reasonable to require the home-based mental health services to be coordinated with the child's case manager, if any, as the requirement clarifies the relationship between the home-based mental health service provider and the case manager, minimizes the possibility of misunderstanding and confusion, and enhances the likelihood of implementing case management activities in a manner consistent with the definition in Minnesota Statutes, section 245.4871, subdivision 3. It also is reasonable because coordination of the child's services is required under Minnesota Statutes, section 245.487, subdivision 3, clause (3) (iii).

Subp. 5. Components of home-based mental health services. This subpart specifies the components of home-based mental health services that, at a minimum, must be available to a recipient and the recipient's family through an eligible provider. Establishing the minimum set of service components is necessary to comply with the requirement of Minnesota Statutes, section 256B.04, subdivision 2 that the medical assistance program be administered statewide in a uniform manner. This subpart assures that a child has access to the full array of services needed by the child without regard to the location of the child's residence. Minnesota Statutes, section 256B.04, subdivision 15 requires the Department to safeguard against unnecessary or inappropriate use of medical assistance services. A child's individual treatment plan specifies the services that a child with an emotional disturbance needs. Thus it is reasonable to recognize that a provider is responsible to provide only those service components specified in a child's individual treatment plan.

Additionally, Minnesota Statutes, section 245.4871, subpart 31 in defining home-based mental health services gives service examples. Some of the examples are health services; some are for recreational or other non-health related purposes such as crisis respite care and assistance in locating respite and child care. However, Minnesota Statutes, section 256B.04,

subdivision 15 limits medical assistance payment for those services that are medically necessary and appropriate for the recipient. Therefore, it is reasonable that subpart 5 limit the required components to medically necessary and appropriate services that are eligible for medical assistance payment because the limitation assures compliance with Minnesota Statutes, section 256B.04, subdivision 15. The services specified in items A to C are health related services needed by the child and the family.

Item A. A diagnostic assessment is necessary to determine whether a child has an emotional disturbance and, if so, its severity. A diagnostic assessment also identifies the mental health services needed by the child. See subpart 3 and its SNR. Part 9505.0323, subpart 2 establishes a diagnostic assessment as the criterion for determining a person's eligibility to receive mental health services under medical assistance. The proposed amendment of part 9505.0323, subpart 2 sets the requirements for completing a new diagnostic assessment and for reviewing and updating a previous diagnostic assessment. Thus it is reasonable to specify that a diagnostic assessment is a required component of a provider's array of home-based mental health services as it is the screening required to determine initial as well as continued eligibility for mental health services under medical assistance including home-based mental health services under EPSDT for children up to age 21, and to identify the mental health services needed by the child. Additionally, the requirement is consistent with Minnesota Statutes, section 245.4871, subdivision 31 which requires home-based mental health services to be designed using information from the child's diagnostic assessment. Because the home-based mental health service provider must design the child's home-based mental health services using the information from the child's diagnostic assessment, it is reasonable to specify a diagnostic assessment as a required component so that the provider will have the information necessary for the design and the child may potentially benefit from receiving the diagnostic assessment and the needed services from same person.

Item B. Individual psychotherapy and family psychotherapy are the first two examples of professional home-based family treatment services specified in Minnesota Statutes, section 245.4871, subdivision 31. The Department notes that the term psychotherapy used throughout proposed item B is synonymous with the term therapy found in examples (1) and (2) of the definition in Minnesota Statutes, section 245.4871, subdivision 31. The Department further notes that multi-family group psychotherapy as set forth in item B is a specialized form of family psychotherapy. Multi-family group psychotherapy, individual psychotherapy, and family psychotherapy are covered mental health services under part 9505.0323.

Literature on mental health services for children published since 1950 has reported these therapies as central to treating the child's symptoms and providing a positive change in the emotional, behavioral, and mental well-being of the child and the child's family. See the attached bibliography . Therefore, the requirement is reasonable as it is consistent with the purposes identified in Minnesota Statutes, section 245.4884, subdivision 3 (a).

Item C. Minnesota Statutes, section 245.4884, subdivision 3 (a) states that treatment must be designed to improve overall family functioning and reduce the risk of the child's out-of-home placement or "reunify the family and reintegrate into the family a child returning from out-of-home placement due to emotional disturbance." Members of the advisory committee reported that

individual, family, and group skills training are a community standard as rehabilitative services that are designed to improve overall family functioning. The training emphasizes daily living skills that assist the family of the child with a severe emotional disturbance. According to the advisory committee, all programs of home-based mental health services in Minnesota at present have these services. Skills training can be provided at lesser cost by trained paraprofessionals who are mental health practitioners as contrasted to the psychotherapies which are reimbursed at a higher rate commensurate with the greater knowledge and skill of the mental health professionals who provide them.

Individual skills training for a child is synonymous with the training in daily independent living and socialization skills which is a component of day treatment services under Minnesota Statutes, section 245.4871, subdivision 10 Skills training as a component of home-based mental health services is a less costly service than day treatment which, as defined in Minnesota Statutes, section 245.4871, subdivision 10, is a structured therapeutic program provided in a three hour time block in a group setting. Skills training under home-based mental health services is recognized by advisory committee members as a cost effective and as a community standard for providing a rehabilitative service that improves family functioning and thereby maintains the child in the home. Subitems (1) to (3) are reasonable as they require the training to be related to activities that promote family understanding of and skill in working with the child, develop parenting skills, and assist the family in maintaining the child at home.

The definition of "community" in item C is necessary to clarify its meaning. Minnesota Statutes, section 245.4884, subdivision 3 states that home-based family services are to assist the child who is at risk of or who is returning from out-of-home placement. The definition of home-based mental health services in Minnesota Statutes, section 245.4871, subdivision 31 states that the services are provided to the child and the child's family "primarily in the child's home environment" but also may "be provided in the child's school, child care setting, or other community setting appropriate to the child." Defining "community" as the child's residence, work, school, or peer group encompasses the settings for the customary activities of children. These settings are appropriately used by groups of children for educational, cultural, vocational, and social purposes. Thus the definition is reasonable as it is consistent with the intent of the definition in subdivision 31 that the services be provided in a community setting appropriate to the child.

Subp. 6. Excluded services. To be eligible for medical assistance payment, Minnesota Statutes, section 256B.04, subdivision 15 requires a service to be medically necessary and appropriate for the recipient. Furthermore Minnesota Statutes, section 256B.04, subdivision 15 requires the department to safeguard against excess or duplicate payments. Minnesota Statutes, section 256B.04, subdivision 12 requires the department to set limits on the types of services covered by medical assistance and the frequency with which the same or similar services may be covered for an individual recipient. See also 42 CFR 440.230 (d) which permits a state agency to place appropriate limits on services "based on such criteria as medical necessity or on utilization control procedures." This subpart is necessary to comply with the cited statutes and federal regulations about setting service limits and to inform affected persons of the limits.

Item A. As stated in subpart 3, a determination of severe emotional disturbance by means of a diagnostic assessment is the criterion for establishing the eligibility of a child and the child's family to receive home-based mental health services. Members of the advisory committee have reported that, under certain circumstances, completing the diagnostic assessment of a child who is experiencing an acute episode of emotional disturbance may be difficult or impossible until the acute episode is resolved. For example, the child may be unable or unwilling to cooperate in activities designed to provide information the mental health professional needs to complete a diagnostic assessment or the child's acute episode of emotional disturbance may be complicated by the child's mental retardation. As a result, it may take the mental health professional a longer period of time or more hours to obtain the information needed to accurately assess the child's functional status and mental health status or to determine the child's mental health service needs. During this period, the child may have an immediate need for home-based mental health services to avoid the risk of out-of-home placement. Members of the advisory committee specifically requested the leeway of up to 30 hours of service pursuant to this item if the child has not had a diagnostic assessment as their experience is the child and child's family may not be capable of assisting the mental health professional. The members report that a child and the child's family must be willing and able to participate in the diagnostic assessment to assure the assessment is complete and accurate. Furthermore, the committee advised that the mental health professional may have to respond first to the child's immediate need for mental health services on an emergency basis. The period of up to 30 hours of service is reasonable as it enables the mental health professional's immediate response to the area of the child's greater need. Although it is reasonable to require a diagnostic assessment to determine whether the child is eligible for the service, it also is reasonable to pay for up to 30 hours of home-based mental health services if the child is later found to have a severe emotional disturbance because, according to members of the advisory committee, this period enables the mental health professional to assess the family dynamics involving the child, to establish a working relationship with the child and the child's family, and to begin treatment needed to keep a child from an out-of-home placement. The members also report that this initial period of service provides an opportunity for the mental health professional to observe the child and to develop a more appropriate and relevant treatment plan than might otherwise have been possible. An appropriate treatment plan meets the requirement of Minnesota Statutes, section 256B.04, subdivision 15 because it provides evidence that enables the Department to safeguard against unnecessary services and to determine whether the recipient's services are medically necessary and appropriate.

Items B to E. These items set service limits as authorized under 42 CFR 440.230 and Minnesota Statutes, section 256B.04, subdivision 12. The limits chosen are based on the Department's consideration of community standards of professional practice reported by members of the advisory committee and also on service levels identified in a Department survey of 12 existing home-based mental health services in the summer of 1991. The Department notes that the limits established in items B to E exceed the level of services provided by 10 of the 12 service providers surveyed. Additionally in setting the limits the Department remained cognizant of the need to find a reasonable balance of the

length and frequency of service needed by most recipients to avoid the risk of out-of-home placement and to remain with the family, the limited resources appropriated to pay for the cost of the home-based mental health services, and utilization control as required under Minnesota Statutes, section 256B.04, subdivision 15.

Item B. As stated in the paragraph above, this limit is based on the service levels of home-based mental health providers reported in the Department's survey. It is calculated based on the provision of an average of seven hours of skills training per week per recipient over the 26 weeks in a six-month period.

Item C. As stated above, this limit is based on the service levels of home-based mental health providers surveyed by the Department. The limit allows 48 hours of psychotherapy within a six-month period or an average of about 1.85 hours of psychotherapy a week for six months, which is consistent with medical assistance mental health rules related to the length of a psychotherapy session. See part 9505.0323, subpart 9 (length of psychotherapy session), subpart 13 (family psychotherapy), and subpart 28 (multiple family group psychotherapy). This item recognizes that circumstances affecting the child or the child's family may result in an acute episode of severe emotional disturbance in the child to the extent that additional psychotherapy is required to meet the emergency and help the child remain in the home. Thus the provision which allows the additional psychotherapy to be given in the event of an emergency is reasonable as the additional psychotherapy is a service needed by the child and is consistent with the program's goal of avoiding institutionalization or out-of-home placement. Prior authorization and after-the-fact authorization are utilization review mechanisms used in the medical assistance program to safeguard against unnecessary services and excess costs as required under Minnesota Statutes, section 256B.04, subdivision 15. To obtain either prior authorization or after-the-fact authorization, a provider must submit to the Department information that documents the recipient's need for the service. Because an emergency may occur at a time when it is impossible to obtain the Department's authorization of the service, for example on a holiday, it is reasonable to permit the mental health professional or practitioner to provide the additional psychotherapy and then to request after-the-fact authorization. Therefore, requiring that the additional hours of psychotherapy receive prior authorization or after-the fact authorization is reasonable as the mechanism provides the department an opportunity to determine whether the additional services are necessary and appropriate for the the child as required by Minnesota Statutes, section 256B.04, subdivision 15. See parts 9505.5010 (prior authorization requirement) and 9505.5015 (after-the-fact authorization). The hours of psychotherapy available under item C are fewer than the hours of skills training under item B. This is reasonable because the home-based mental health providers surveyed by the Department reported skills training to be their major service area.

Item D. The Department's survey of home-based mental health providers showed that 240 hours of skills training within a six-month period exceeds the average level reported. However, members of the advisory committee and surveyed providers reported that some clients have an acute need for skill training beyond the 240 hour limit. Thus, this item reasonably permits prior authorization to exceed the limit as prior authorization provides the

Department an opportunity to determine whether the additional services are medically necessary and appropriate for the child as required under Minnesota Statutes, section 256B.04, subdivision 15. See part 9505.5010 in regard to prior authorization.

Item E. Psychotherapy is an outpatient mental health service, that is provided as a rehabilitative service for maximum reduction of mental disability and restoration of a recipient to his best possible level of functioning. Minnesota Statutes, section 256B.02, subdivision 7 sets the minimum professional standards applicable to medical assistance vendors amd requires that a vendor be licensed. Part 9505.0323, subpart 23 requires psychotherapy services to be provided by mental health professionals as a condition of eligibility to receive medical assistance payment for the service. Part 9505.0175, subpart 28 and its proposed amendment specify the persons who are licensed or certified as mental health professionals in accordance with state law. See the SNR of the proposed amendment of part 9505.0175, subpart 28. This item is reasonable as it assures consistency with Minnesota Statutes, section 256B.0625, subdivision 24 which requires licensure or recognition under state law as a condition of eligibility to receive medical assistance paymment for medical or remedial care. See part 9505.0323, subpart 31 which sets forth the circumstances under which a mental health practitioner may be a provider of mental health service.

Item F. Minnesota Statutes, section 245.4884, subdivision 3, paragraph (b) states that home-based mental health services "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..." This item limits medical assistance payment for skills training to a team that is comprised of a a mental health practitioner and a mental health professional who accepts responsibility for and provides on-site observation of the services of the mental health practitioner. As used in proposed part 9505.0324, both the mental health professional and practitioner are required to have skills and training related to services for children. See Minnesota Statutes, section 245.4871, subdivisions 26 and 27 and the definitions in the proposed amendments to part 9505.0175, subparts 27 and 28 which apply to medical assistance providers. The standards for the independent practice of psychotherapy and clinical supervision by a mental health professional differ from those required for services provided by a mental health practitioner. The standards for the mental health professional require more training and experience than those for a mental health practitioner. Those more rigorous standards are consistent with the comments of the advisory committee that the skill and educational levels necessary to provide skills training are less than those required to provide psychotherapy or other mental health services. However, knowledge of severe emotional disturbance and its manifestations and effects on the child and the child's family are necessary so that the skills training will be appropriate to the needs of the child and the child's family. A mental health practitioner although not licensed or certified in the provision of mental health services does have training and experience in working with and in the delivery of mental health services to children with severe emotional disturbance. See Minnesota Statutes, section 245.4871, subdivision 26 which defines mental health practitioner. Thus, excluding from eligibility for medical assistance payment services under this part that are provided by persons who are not qualified at least as mental health

practitioners and therefore do not have at least the minimum training and experience in the delivery of mental health services to children with severe emotional disturbance is reasonable as it assures at least a minimum level of quality of services. Because of the mental health practitioner's relatively less knowledge about severe emotional disturbance and its treatment compared to that of a mental health professional, it is reasonable to require that a mental health practitioner maintain a professional consulting relationship with a more highly qualified provider. Such a person is a mental health professional who can provide ongoing clinical supervision and direction and accept professional responsibility for the skills training which is being provided as a mental health service. It is reasonable to require the mental health professional to accept professional responsibility because accepting professional responsibility is consistent with the statutory authorization of the mental health professional to provide clinical supervision as set forth in Minnesota Statutes, section 245.4871, subdivision 7. Accepting full professional responsibility is consistent with the professional practice standards set by the boards that license or certify mental health professionals. See the definition of mental health professional in Minnesota Statutes, section 245.4871, subdivision 27, which specifies the education and experience required by the state for licensure or certification and Minnesota Statutes, section 245.4871, subdivision 7 which defines clinical supervision as a service accomplished by mental health professionals.

One on-site visit by the mental health professional within the first six hours of service in which the practitioner provides the skills training is a minimum intrusion into the therapeutic process according to the advisory committee. At the same time the standard serves as a quality assurance mechanism that protects the recipient and the recipient's family by assuring that the services are being given by a qualified person in the manner determined necessary and appropriate by the mental health professional. It is reasonable to require further on-site observations as clinically appropriate as the mental health professional is qualified by licensure or certification to make clinical judgments about mental health services, including the appropriateness and necessity of the skills training given to the child and the child's family. A signed entry of the on-site visit in the child's record provides reasonable evidence of compliance with the on-site visit requirement.

The Department notes that under very limited circumstances a mental health practitioner is eligible to receive medical assistance payment for psychotherapy to children. See part 9505.0323, subpart 31 which sets forth the circumstances and requires the services to be provided under the clinical supervision of a mental health professional.

Item G. This item states the negative of the requirement set forth in subpart 5. It is reasonable as it is consistent with subpart 5 and provides a further opportunity to inform providers of their service obligations to recipients. See subpart 5 and its SNR.

Item H. In connection with this item, the Department notes that under very limited circumstances a mental health practitioner is eligible to receive medical assistance payment for psychotherapy to children. See part 9505.0323, subpart 31 which sets forth the circumstances and requires the services to be provided under clinical supervision.

Minnesota Statutes, section 256B.04, subdivision 15 requires the Department to safeguard against unnecessary services and excess medical assistance payments.

Except under limited and unusual circumstances, home-based mental health services by more than one mental health professional or practitioner simultaneously result in unnecessary services and excess medical assistance payments. Therefore, prohibiting payment for such duplicate services is reasonable as it ensures consistency with the statutory requirement. However, it also is reasonable to provide a mechanism that will allow for simultaneous services by more than one professional or practitioner when these services are necessary and appropriate for the child. Prior authorization provides the Department the opportunity to determine the necessity and appropriateness of the services and thus to fulfill the requirement of Minnesota Statutes, section 256B.04, subdivision 15. See the definition of prior authorization in part 9505.0175, subpart 37 and parts 9505.5000 to 9505.5030 which set forth the requirements.

Item I. Minnesota Statutes, section 256B.04, subdivision 15 requires the Department to safeguard against excess medical assistance payments. To carry out this requirement, medical assistance is used as the payer of last resort. See part 9505.0070, subpart 2 about medical assistance as payer of last resort, and parts 9505.0015, subpart 46 and 9505.0175, subpart 48 which define third party payer for purposes of the medical assistance program. Thus, it is reasonable to prohibit medical assistance payment if the home-based mental health services duplicate health services funded by another program because the prohibition is fiscally responsible and consistent with the cited statutory and regulatory requirements.

The purpose of providing home based mental health services is to prevent the out-of-home placement of a child at risk or to assist the child to return home from an out-of-home placement. Because eligibility for home-based mental health services is limited to children with severe emotional disturbance who are at risk of out-of-home placement, the child's need for home based mental health services is expected to be time limited as Minnesota Statutes, section 245.4884, subdivision 3, paragraph (a) requires the services to be designed to treat the symptoms of emotional disturbance that contribute to the risk of out-of-home placement and to improve the overall family functioning and provide a positive change in the emotional, behavioral, and mental well-being of the child and family. Furthermore as stated in subpart 1, item D, the purposes of the services are aimed at resolving the acute episode of emotional disturbance. Advisory committee members stated that a child with severe emotional disturbance whose service needs are in transition may need concurrent mental health services from two different providers as a means to assure a successful transition. Subitem (1) authorizes the concurrent provision of a limited number of hours of day treatment and home-based mental health services if these concurrently provided services are identified with the goals in the child's treatment plan. Day treatment as defined in Minnesota Statutes, section 245.4871, subdivision 9 is a structured program of treatment and care provided to more than one child at a time in a setting other than a home whereas home-based mental health services are provided primarily in the child's home to the child and the child's family. Concurrent provision of these two mental health services that differ in their setting and structure provides an opportunity for the child to make a transition from one service to the other. This exception is reasonable because members of the advisory committee who were experienced in providing both day treatment and home-based mental health services to children stated that concurrent service

provision enhances the probability the child will make a successful transition.

Part 9505.0323, subpart 15 limits payment for day treatment to the program provided in a three-hour time block. 60 hours of day treatment allows for 20 days of concurrent day treatment and home-based mental health services. Because day treatment is customarily provided no more than five days per week, the limitation will permit one month of continuous service without prior authorization. However the service transition for children with severe emotional disturbance may be affected by circumstances beyond the control of the child, the child's family, or the child's mental health service providers and thereby be delayed beyond the expected completion date. Examples of these circumstances which cannot reasonably be anticipated are a serious illness of the child or a member of the child's family, the death of a sibling or parent, or a necessary relocation of the child's family because of change in the family's employment or economic circumstances. It is reasonable to allow for this possibility by providing a mechanism for the Department to review the need for, and if appropriate authorize, a continuation of the concurrent services. Prior authorization provides the Department the opportunity to determine the need and appropriateness of the services and thus to fulfill the requirement of Minnesota Statutes, section 256B.04, subdivision 15. See the definition of prior authorization in part 9505.0175, subpart 37 and parts 9505.5000 to 9505.5030 which set forth the requirements.

Subitem (2) allows payment for the concurrent provision of home-based mental health services and individual psychotherapy for the child or family psychotherapy for the child's family. As discussed above concurrent provision of services may be necessary and appropriate to insure a successful transition from home-based mental health services. A child receiving individual psychotherapy as an outpatient mental health service may experience an acute episode of emotional disturbance and become at risk of out-of-home placement. The mental health professional providing the psychotherapy for the child will have knowledge of the child's mental status including the child's diagnostic assessment, functional assessment, and individual treatment plan. The child's mental health professional will have established rapport with the child and the child's family. It is reasonable to require the mental health professional providing the psychotherapy as an outpatient mental health service to refer the child and to work with the home based mental health service provider as the requirement facilitates cooperation and communication between the child's two mental health service providers and thereby enhances the likelihood of benefits to the child and the child's family.

Item J. As stated in Minnesota Statutes, section 245.4871, subdivision 31 home based mental health services are to be provided "to the child and the child's family primarily in the child's home environment." Subdivision 31 also states that home based mental health services may be provided in the "child's school, child care setting, or other community setting appropriate to the child." The intent of subdivision 31 is clearly that the child receiving the home based mental health service is living in his or her residence. See also the proposed definition of residence in subpart 1, item F. Thus the prohibition of medical assistance payment for home-based mental health services provided when the child is not living in the child's residence is reasonable as it is consistent with subdivision 31.

However, Minnesota Statutes section 245.4871, subdivision 31 also states that

home-based mental health services are mental health services provided to children because of an emotional disturbance who are returning from out-of-home placement. A child may have difficulty in making a successful transition from an out-of-home placement to living with his or her family in a home environment. A child with severe emotional disturbance whose mental health service needs are in transition may need concurrent mental health services from two different providers as a means to assure a successful transition. In the circumstances under item J, the child is moving from a controlled environment which includes mental health services to a less restricted environment and mental health services of a different nature. Thus it is reasonable to provide medical assistance payment for the concurrent provision of home-based mental health services and the services the child with severe emotional disturbance is receiving in an institutional or residential setting because, according to members of the advisory committee who provide home-based mental health services, the concurrent provision of these mental health services enhances the probability the child will make a successful transition. Discharge planning and an individual treatment plan are elements required for a child's transition to the community under Minnesota Statutes, sections 245.4882, subdivisions 3 and 4 and 245.4883, subdivision 1(5) and subdivision 3. They are reasonable requirements as they inform the child's multiple providers of the child's mental health status, service needs related to treatment plan goals, medication regimes, and treatment goals and assist the coordination and implementation of the needed services in an appropriate and efficacious manner.

Item K. This item is reasonable as it clarifies and informs affected persons that home-based mental health services that do not comply with the requirements of part 9505.0324 are not eligible for medical assistance payment.

Subp. 7. Required training. This subpart establishes a minimum level of continuing education in the case of a mental health practitioner. Standards of practice change as new information about a disorder or its treatment becomes available. Persons practicing in professional areas such as nursing, mental health, and medicine are required to refresh their knowledge of their subject areas and to remain up-to-date with current knowledge and standards of professional practices as a way to assure their clients will receive at least a minimum level of quality service. Even though the qualification standards for practitioners are less rigorous than those for their clinical supervisors, the mental health professionals, all of whom must meet continuing education requirements to retain their licensure or certification, it is reasonable to require mental health practitioners also to meet a continuing education requirement related to serving the needs of children with severe emotional disturbance because it assures that their services are consistent with current standards of practice. The use of the current standard of practice by the mental health practitioner assists the supervisory activities of the mental health professional who is providing the required clinical supervision. That the entity employing the practitioner must provide the required training is reasonable as the employer has an obligation to assure that the practitioner has the ability to provide at least a minimum level of quality service according to current standards of community practice. Requiring the practitioner's employer to document completion of the requirement is

reasonable as the documentation is evidence of compliance and provides an audit trail. 15 hours per calendar year is a commonly accepted standard required for continuing education in a health related field. For example, licensed social workers must fulfill 45 hours in each 3 year period; certain licensed social workers provide mental health case management services. Thus requiring 15 hours per calendar year is reasonable because it does not impose an additional burden on persons eligible to be mental health practitioners and is consistent with the continuing education standards of the practitioner's professional licensing board.

Subp. 8. Travel to child's treatment setting. This provision is not in the emergency rule in effect during calendar year 1992. This subpart sets forth a provision related to the mental health professional's travel to a child's treatment setting.

Minnesota Statutes, section 245.4871, subdivision 31 states that home based mental health services are to be provided "to the child and the child's family primarily in the child's home environment." Subdivision 31 also states that home based mental health services may be provided in the child's school, child care setting, or other community setting appropriate to the child." Thus a person providing home based mental health services has to travel to the setting appropriate to the child. Furthermore, the Department recognizes that mental health professionals who provide home-based mental health services to children who live in greater Minnesota may have to spend considerable time traveling long distances to the setting appropriate to the child. It is reasonable to provide medical assistance payment for such travel as the travel requires an expenditure for transportation and may decrease the time in which the mental health professional is available to provide covered services to other clients. Part 9505.0491, subpart 7 and 8 are the present rules which set the payment rate and the rates annual adjustment factor for mental health case managers. The rate set for a case manager in part 9505.0491, subpart 7, $30, is the same as the rate paid for a mental health practitioner providing individual and family living skills under part 9505.0324. The rate is lower than the customary rate of $66 per hour for psychotherapy by a psychologist with a Ph.D or a psychiatrist and the rate of $43 per hour for other mental health professionals providing mental health services for the period in which a mental health professional provides mental health services including home-based mental health services. However, home-based mental health services are provided directly to a child or the child's family as required under part 9505.0220, item L but the mental health professional in transit is not providing a health service directly to the child or the child's family. The use of the lower rate and adjustment factor is reasonable as it balances the mental health professional's need to receive adequate compensation for travel and potential loss of income during the travel and the Department's obligation to use medical assistance funds to pay for direct services to recipients.

As discussed in the fiscal note accompanying this rule, payment for travel is a particularly uncertain cost component of home-based mental health services. To assure that medical assistance expenditures do not exceed the budgeted amount, this subpart includes the contingency that reimbursement for travel will end June 30, 1993 if the Legislature does not approve a statutory amendment proposed by the Department. This contingency is reasonable as it is consistent with maximizing the use of available funds to pay for direct services needed by clients. Furthermore it is reasonable to limit the number

of payments for travel for home-based services to a client as the limit also is consistent with maximizing the use of available funds to pay for the client's direct services and is consistent with the time-limited concept of the need for home-based mental health services.

The Department notes that the use of medical assistance funds to pay for the travel of mental health professionals providing home-based mental health services must receive approval as a covered service incorporated in the approved State Medicaid Plan. The approval must be given by the Health Care Financing Administration (HCFA) of the United States Department of Health and Human Services. Thus if the approval is not given, the Department will not have the authority to use medical assistance funds for this purpose. See 42 CFR 430.10 to 430.15 about State Plan approval by HCFA. A possible consequence of using medical assistance funds for a purpose other than one specified in the State Medicaid Plan is HCFA's withholding of future federal payments. See 42 CFR 430.35 about withholding of funds for failure to comply with the approved State Plan. Therefore, it is necessary and reasonable to provide that implementation of this subpart is subject to HCFA's approval because the Department must comply with the HCFA approved State Plan or risk incurring an adverse fiscal consequence. See also Minnesota Statutes, section 256B.04, subdivision 4 which requires the Department to cooperate with the federal government in any reasonable manner as may be necessary to qualify for federal financial participation in the medical assistance program.

Expert Witnesses

The Department will not present expert witnesses other than Department staff members to testify on behalf of the Department concerning the provision of these proposed rules.

June 25, 1992

NATALIE HAAS STEFFEN, Commissioner
for Department of Human Services