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STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Adoption of Rules of the Department of Human Services Governing Case Management Services for Persons With Mental Retardation or Related Conditions (Minnesota Rules, parts 9525.0004 to 9525.0036 [proposed]); and Technical Amendments to Other Department of Human Services Rules Governing Related Services.

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

Proposed rule parts 9525.0004 to 9525.0036, establish standards that govern provision of case management administration and case management services to persons with mental retardation or related conditions by county boards or others authorized by the Commissioner to provide case management.

Currently, rule parts 9525.0015 to 9525.0165 govern case management services for persons with mental retardation or related conditions. Parts 9525.0015 to 9525.0165 were promulgated in 1986. No amendments have been made since that time. Rule parts 9525.0180 to 9525.0190 currently govern diagnostic requirements for related conditions. These diagnostic requirements are being incorporated into parts 9525.0004 to 9525.0036, which will result in a single rule governing case management and the diagnosis of mental retardation or related conditions for purposes of eligibility for case management. Due to the substantial extent of reformatting and revision required and upon the recommendation of the advisory committee, parts 9525.0015 to 9525.0165 and parts 9525.0180 to 9525.0190 will be repealed at the time proposed parts 9525.0004 to 9525.0036 are promulgated.

Authority for the proposed rule as well as the repealed rule parts is contained in Minnesota Statutes, section 256B.092, which directed the Commissioner to adopt rules which establish policy and procedures to reduce duplicative efforts and unnecessary paperwork on the part of case managers. Minnesota Statutes, section 256B.092, was significantly amended in the 1991 session which necessitated the repeal and redrafting of the case management rule. In summary, these amendments resulted in the

following changes: 1) reduction of duplication of efforts in the areas of diagnosis, assessment, and service plan development; 2) elimination of the habilitation component of the service plan and clarification of the provider's role in developing the individual program plan; 3) separation of the administrative and service functions of case management; 4) provision for free choice of vendor of case management services for recipients of home and community based services effective July 1, 1992; 5) clarification of the host county concurrence requirements; 6) provision for waivered services demonstration projects; 7) clarification of discharge planning requirements for persons in Regional Treatment Centers assuring consistency with other statutory language; and 8) technical edits to update or clarify statutory language.

The major objectives in repealing parts 9525.0015 to 9525.0165 and parts 9525.0180 to 9525.0190 and redrafting the case management rule are to: 1) incorporate changes in statutory authority as well as federal standards; 2) organize the rule in a more user-friendly style reflecting the actions of the county in a chronological manner; 3) streamline and reduce duplication by incorporating county board responsibilities and administrative functions into parts 9550.0010 to 9550.0092; 4) incorporate the diagnostic requirements for related conditions into proposed parts 9525.0004 to 9525.0036 and repeal parts 9525.0180 to 9525.0190, resulting in a single diagnostic rule for persons with mental retardation or related conditions; 5) assure the case management system treats the customer with the highest degree of respect and dignity while facilitating consumer choice, and control and autonomy; 6) support family system approaches to services, greater self- sufficiency for families, and greater flexibility in the way families are provided services and supports; and 7) allow flexibility and diversity in the achievement of outcomes.

Due to the repeal of parts 9525.0015 to 9525.0165 and parts 9525.0180 to 9525.0190, and the renumbering of the case management rule, it is necessary to amend a number of other Department rules which currently cross-reference parts 9525.0015 to 9525.0165 or parts 9525.0180 to 9525.0190, or refer to the requirements of these parts in some manner. These amendments are technical in nature only. All such technical amendments are addressed at the end of this statement of reasonableness.

BACKGROUND AND OVERVIEW OF CASE MANAGEMENT FOR PERSONS WITH MENTAL RETARDATION AND RELATED CONDITIONS

Minnesota's commitment to case management for persons with mental retardation or related conditions is reflected in more than a

decade of state law. First mandated as a required service in 1977, case management is now the cornerstone of all services provided to this population by county social services agencies. Since its origin, Minnesota Statutes, section 256B.092 has been refined and clarified by several legislatures, most recently in 1991 when significant changes were made in the language of the law to streamline and simplify the procedures while preserving the intent of the law and the key components of the case management process.

The intent of providing case management services for persons with mental retardation or related conditions is to assist persons in gaining access to needed social, medical, educational and other supports and services. The case manager works on the behalf of the person to identify their unique needs and to minimize the impact of the disability on the person's life while assuring continuity of quality services and supports for the person. Case management has been identified as a vital service when considering the complexity of providing community based services to people with changing and emerging needs. Organizing community systems to meet a person's service and support needs and assuring consistent approaches among providers requires skills in coordination and evaluation of services, negotiating and actively promoting, and the knowledge of and access to ordinary and specialized community resources. It also requires a commitment to the values and principles associated with quality services for persons with mental retardation or related conditions. The importance of the case management system is illustrated by the following: 1) the impact of the continued deinstitutionalization of persons with mental retardation and related conditions; 2) the fragmentation of community social services as well as other vital community services; and 3) the recognition that persons with disabilities have the same essential needs as the rest of society for social inclusion, family and relationships.

While parts 9525.0015 to 9525.0165 as promulgated in 1986 identified desired outcomes of provided services, the values and service principles inherent in the rule were often overshadowed by process requirements. This focus on process compliance was reinforced in appeal decisions and in the state's role of monitoring the delivery of case management services. While the intent of the state agency monitoring unit was to evaluate the delivery and quality of county case management services, a licensing approach was used to quantitatively measure compliance with specific process oriented rule parts. Specific process deficiencies were identified and measured from the paper record or the lack of a paper record. With the exception of a recent independent study of service in Minnesota, the history of evaluating the delivery and effectiveness of case management has

relied almost entirely on measuring what was done and recorded by the case manager rather than what was achieved by or for the customer. While consumer satisfaction was mentioned in training manuals, methodology for identifying satisfaction was not sufficiently developed or taught.

With the ever increasing administrative and service responsibilities placed on county agencies in response to their request to do community social service planning and service development, and with the added complexity in administrative responsibilities resulting from greater access to federal dollars, county agencies sought relief from process standards and duplication of effort. At the same time however, counties placed emphasis on the process compliance with the case management rule. They too assumed that process would result in desired outcomes while protecting counties from the need to do correction plans or be fined when monitored by the state agency. To a certain extent, it was true that insuring process produced some improved outcomes for people. Case managers became more familiar with the person's needs, and became pro-active in seeking out less restrictive community based services. While compliance with process standards assured certain minimal consistency among counties providing case management, it also allowed and required duplication of effort made by other providers who were also charged with the same or similar requirements by their own licensing and certification standards. This duplication sometimes created an unnecessary conflict between agencies rather than a healthy balance and friction based on separation of responsibilities. As a result of the emphasis on detailed process requirements, process became the end in itself for many case managers. This unintended result was confirmed in surveys of case managers, state monitoring of case manager activities, and testimony from parents, consumers, advocates and providers.

When the state agency evaluated the Minnesota case management system in 1990, there was a desire to propose a streamlined and more flexible system while recognizing and reinforcing the strengths of the current service delivery system. Resources were limited and streamlining and elimination of duplicative processes were necessary in order to free up time for case managers to focus on achieving identified goals and desired service outcomes.

Proposed parts 9525.0004 to 9525.0036 do not eliminate all process requirements. Minimum process standards are maintained when deemed necessary and in an effort to inform consumers of what are reasonable expectations of case management. The proposed rule does, however, eliminate unnecessary process and duplication of effort. Quality case management implies ever changing strategies when existing strategies fail. Rules must

afford enough flexibility to the individual case manager to accomplish the goals of services and supports for persons with disabilities. The proposed rule places the greatest emphasis on the outcomes and goals for persons with mental retardation and related conditions while assuring quality services, and protection of health, safety, legal and civil rights. Proposed parts 9525.0004 to 9525.0036 also emphasize that outcome evaluation is essential. Prudent use of public funds requires that we purchase outcomes rather than good intentions. Performance based contracting is no longer a thing of the future, but a reality as well as a necessity of the present. If we identify quality services as those that comply with our process requirements but never achieve or approximate the identified outcomes, we are very likely wasting some of the state's valuable and limited resources.

RULE DEVELOPMENT PROCEDURE

A Notice of Solicitation of Outside Information or Opinions for the purpose of proposing amendments to parts 9525.0015 to 9525.0165 was published in the State Register on August 12, 1991. Upon the Department's determination to combine the diagnostic requirements for mental retardation and related conditions into one rule, a Notice of Solicitation regarding the proposed amendment and possible repeal of parts 9525.0180 to 9525.0190, which governs services to persons with related conditions, was published in the State Register on December 2, 1991.

The Department reviewed the potential scope, content, and impact of the proposed rule amendment and formed an advisory committee comprised of affected parties. The advisory committee included representation from county agencies, consumers of case management, parents, advocates, service providers, and the Department. A total of eight committee meetings were held from October 1991 through July 1992. Further public input was obtained through regional public informational meetings, which were conducted during April and May 1992 with attendance in excess of 500 persons.

NEED AND REASONABLENESS OF SPECIFIC RULE PROVISIONS

The specific provisions of proposed parts 9525.0004 to 9525.0036 are affirmatively presented by the Department in the following narrative which constitutes the Statement of Need and Reasonableness, in accordance with the Minnesota Administrative Procedure Act, chapter 14, and the rules of the Office of Administrative Hearings. The term "developmental disabilities"

is used throughout parts 9525.0004 to 9525.0036 in reference to literature and federal authority. Developmental disabilities as a discipline includes a number of disabilities in addition to mental retardation and related conditions. However, for purposes of parts 9525.0004 to 9525.0036, which will govern case management for persons with mental retardation or related conditions, when the term "developmental disabilities" is used in this Statement of Need and Reasonableness, it is intended by the Department to refer to only those persons who have mental retardation or a related condition. For purposes of making the rule more user-friendly through better organization of the requirements, the rule is reformatted by repealing parts 9525.0015 to 9525.0165 and 9525.0180 to 9525.0190 and renumbering the rule as parts 9525.0004 to 9525.0036. Format changes are indicated in the following Statement of Need and Reasonableness.

PART 9525.0015 [See repealer].

The repeal of this part is essentially a format change. The terms which have a meaning specific to parts 9525.0004 to 9525.0036 have been moved to part 9525.0004. The deletion of part 9525.0015 is reasonable to accomplish the format change.

PART 9525.0004 DEFINITIONS.

This rule part defines words and phrases that have a meaning specific to parts 9525.0004 to 9525.0036, that may have a number of possible interpretations, or that need exact definitions to be consistent with statute. Terms used in a manner consistent with common usage in the field of developmental disabilities or human services are not defined unless a definition is necessary to clarify the rule. In a number of cases, the definitions include terms previously defined in part 9525.0015 and contain only format changes which are necessary due to the renumbering of the rule parts.

Subpart 1. **Scope.** This provision is necessary to clarify that the definitions apply to the entire sequence of parts 9525.0004 to 9525.0036. The change to this subpart is necessary to delete reference to the former case management rule parts. Since parts 9525.0015 to 9525.0165 are being repealed, it is reasonable to delete reference to those rule parts.

Subpart 2. **Advocate.** This subpart modifies the definition previously found in part 9525.0015, subpart 3. The primary change to this definition is the addition of the requirement that an individual formally advocating for a person in the case

management process, for example, for screening and service planning purposes, or the individual's employer must have no direct or indirect financial interest in the provision of services or supports they are advocating that the person receive. It is reasonable to require that the advocate and the advocate's employer have no direct or indirect financial interest in the provision of those services or supports to the person in order to facilitate the provision of objective representation and to avoid any conflict of interest. It is reasonable to avoid such a conflict of interest to facilitate protection of the person's best interests. This avoidance of conflict of interest is consistent with both state and federal law.

The *Developmental Disabilities Assistance and Bill of Rights Act* requires that:

> [T]he State must have in effect a system to protect and advocate the rights of persons with developmental disabilities; such system must...be independent of any agency which provides treatment, services, or habilitation to persons with developmental disabilities.

42 U.S.C. §6042 (emphasis added).

In addition, the Code of Federal Regulations, title 42, § 441.302(d) requires as a condition of a grant of a medicaid waiver that the state provide assurances to the Health Care Financing Administration (HCFA) that:

> [W]hen a recipient is determined to be likely to require the level of care provided in an SNF, ICF, or ICF/MR, the recipient or his or her legal representative will be-
> (1) Informed of any feasible alternatives available under the waiver; and
> (2) Given the choice of either institutional or home and community-based services.

(emphasis added).

This assurance has been met in Minnesota through the following requirements: 1) the person or their legal representative must be informed by the case manager at the time of the screening of feasible alternatives under the waiver; 2) if eligible, the person must be allowed at the time of the screening to choose between ICF/MR services and home and community-based services (See current part 9525.0065, subpart 4 and proposed part 9525.0016, subpart 8); 3) through limiting the screening and service planning team to the case manager, the person, the person's legal guardian or conservator, the parent if the person

is a minor, and a qualified mental retardation professional (Minn. Stat. § 256B.092, subd. 7; current parts 9525.0015, subpart 31 and 9525.0075, subpart 1, and part 9525.0004, subpart 26 as proposed); 4) the person has the right to a hearing under Minn. Stat. § 256.045 if the person is not adequately informed or given the right to choose feasible service types that they may be eligible to receive; and 5) no member of the screening team shall have any direct or indirect service provider interest in the case (Minn. Stat. § 256B.092, subd. 7).

(emphasis added).

The purpose of the above requirements is to assure that the person is given an informed choice, recognizing that informed choices requires the choice be voluntary and free from outside influence. The composition of the screening team as defined in both rule and statute has been accepted by HCFA as part of Minnesota's assurances to the federal government in compliances with the requirements of the Code of Federal Regulations, title 42, section 441.302. These assurances have been incorporated into Minnesota's waiver plan for persons with mental retardation or related conditions with which the state must comply as a condition of receiving federal funding.

Minnesota Statutes, section 256B.092, subdivision 8 requires the screening team to review diagnostic and assessment data, identify appropriate levels of services to maintain the person in the least restrictive setting, identify needed social, residential and non-institutional services, make recommendations regarding placement and payment for services, and evaluate the availability, location and quality of recommended services. By granting the screening team this authority, the legislature has affirmed that the system if services in Minnesota provided to the person based on their assessed needs and preferences must be consumer, not provider-driven.

It is important to note that section 256B.092, subdivision 7 requires the case manager to serve as a member of the screening team. The role of the case manager in the context of the screening team is to assure that the person has an informed choice of services. The case manager does not serve as the advocate. Rather, it is the person who is provided the opportunity to make an informed choice of services. The case manager must remain neutral when giving the person a choice of services which they are eligible to receive.

An illustration of the importance of neutral representation would be a case where person with mental retardation has been determined to be eligible for ICF/MR level of care. As stated

above, Code of Federal Regulations, title 42, §441.302(d) requires that the person be given the choice by the case manager at the time of screening of either institutional or home and community-based services. Part 9525.0016, subpart 8 implements this requirement. If the person chooses the ICF/MR, the persons choice is to be respected, notwithstanding the fact that the case manager may feel a waivered service would be a better service choice.

The provision under the proposed definition that the advocate must have no direct or indirect financial interest in the provision of services to the person is consistent with the aforementioned state and federal requirements and facilitates a truly informed choice regarding services.

There was a general consensus among the rule advisory committee that in order to provide objective representation, the advocate must be devoid of external pressures that may cause or be perceived to cause a conflict of interest. While the advisory committee agreed that service providers should actively promote the interests of the person and that internal provider support systems should be offered to persons with developmental disabilities, the committee affirmed that the role of advocacy should be free from any special interests that service providers have that might prevent the advocate from representing only the interests of the person.

The definition of "advocate" as used in the case management process is tied to the concept of "informed choice", meaning that for true informed consent to be obtained, the advocate must be free from conflict of interest due to a direct or indirect service provider interest. The proposed definition promotes informed and voluntary choices regarding services and the person's life overall.

The three legal elements of informed consent are capacity, information, and voluntariness. See, *A History and Theory of Informed Consent*, Ruth R. Faden & Tom L. Beauchamp, 1986; *Informed Consent: Legal Theory and Clinical Practice*, Paul S. Appelbaum, Charles W. Ledz & Alan Meisel, 1987; *Consent Handbook*, American Association on Mental Deficiency (AAMD), 1977. The importance of voluntariness of consent is a well-established legal principle. The *Restatement of Torts*, vol. § 892B[3] states that "consent is not effective if it is given under duress." The *American Heritage Dictionary* defines the term "voluntary" as "arising from one's own free will; acting on one's own initiative; acting or performed without external persuasion or compulsion." Second College Edition, 1985, page 1355. Voluntariness is defined in the legal context of informed consent

as meaning that "the person involved should be so situated as be able to exercise free power of choice, without the intervention of any element of force, fraud, deceit, or other ulterior form of constraint or coercion." *A History and Theory of Informed Consent*, Id. at 256; See also, *Consent Handbook*, supra, at 10. Frequently, voluntariness consists of the absence of overbearing coercion, duress, threats or inducements, and undue influence. *Legal Challenges to Behavior Modification*, Reed Martin, 1975, p. 29. The significance of the absence of influence, coercion, etc., is evident in the following legal principles: 1) wills are voided if the testator was subjected to undue influence, *Restatement of Torts*, vol. 70, §§5.7, 15.11; 2) criminal confessions are void if coerced, Id. §71; and 3) contracts entered into under duress are voidable, Id. at vol. 72, §175. No lesser standard should apply to protecting the rights of persons with mental retardation or related conditions. It is essential that the role of advocate be neutral, objective and free from conflict of interest in order to ensure voluntariness. The proposed definition protects the person's autonomy and integrity by ensuring that the person's choice is voluntary.

Further, as the AAMD noted in its discussion of consent, in the case of persons with mental retardation the test of voluntariness is compounded. For example, is a person with mental retardation more likely to give consent because the person is overly eager to please and to do as others ask them to do? Or, is the person more susceptible to inducements because of limited mental capacity. *Consent Handbook*, supra, at 11.

Because of the unique vulnerabilities of this population, including the vulnerability to overreaching by service providers, there would surely be a conflict of interest for a service provider to serve as the person's advocate. It is appropriate, then, that when advocacy services are indicated or requested, both the case manager and the service provider assist the person or the person's family or guardian to access neutral, external advocacy services. Through the separation of formal advocacy from the roles of case managers and service providers, the protection of the person is promoted.

It is important to note that the proposed definition does not prohibit service providers from actively promoting the interests of persons with developmental disabilities. Rather, it prohibits a person from acting or being recognized as acting as the formal advocate in the case management process when that person has a direct or indirect financial interest in providing the services or supports they are advocating that the person receive. Accordingly, under the proposed definition, the rule would not recognize a service provider who provides services to the person

as the formal advocate who is to speak on the person's behalf in matters regarding case management under parts 9525.0004 to 9525.0036.

Service providers and employees of service providers may continue and are encouraged to attend and participate in meetings regarding services and programming for the person. Input of such knowledgeable and caring staff is invaluable. It is true that the role of each interdisciplinary team member, including service providers, contains elements of advocacy (i.e. providing insight into the best interests of the person). Interdisciplinary team members' roles are varied, but share a common theme regarding attempting to provide the best possible experience for persons with mental retardation or related conditions, taking into account the individual's preferences, interests, and service and treatment needs.

In addition, interdisciplinary team members, as defined under proposed part 9525.0004, subpart 14, seek to insure that both federal and state guidelines regarding treatment, support and supervision are met. The interdisciplinary team is different from the screening or service planning team. The primary role of the interdisciplinary team is to develop program plans based on the person's service plan. It is expected that team members, including services providers, provider information, freely discuss that information and then act upon that information in the form of a treatment plan. Persons participating in the team process share their expertise based on their education, experience and knowledge, be it from a highly technical or professional point of view (i.e. physician, psychologist) to that of general observations and opinions of direct care staff. Each viewpoint is respected, but contains perspectives from the member's respective discipline.

Individual perspectives of interdisciplinary team members should be considered as they relate to the care, support and treatment of persons with mental retardation or related conditions. However, these team members' roles are different from that of a formal advocate. The formal advocate's role is to speak on the person's behalf representing the best interests of the person. This perspective may, at times, be different than what other team members are supporting. Team members are placed in the position of balancing what is best for the person against the interests of the service provider(s). Advocates do not have to weigh the interests of the services providers, but only what is in the best interest of the person.

The advocate speaking on behalf of the person must not be put in a position where he or she must consider his or her employment or

what may affect the employer/service provider(s), but only in what is in the best interest of the person. As Cohen points out in *The Mentally Retarded Citizen and the Law*, it is essential for an advocate to have a clear orientation toward their client. The *President's Committee on Mental Retardation*, Michael Kindred, Juilius Cohen, David Penrod & Thomas Shaffer, 1976. As such, the role of advocate is substantially different from that of other team members, including service providers. Clearly, interdisciplinary team members may be influenced by those factors which affect the service provider with whom they are employed. For example, it is a reality that staff are influenced by budgetary factors. Multiple responsibilities and interests of service providers may create bias and serve to limit the staff person's ability to objectively represent the client's best interests as an advocate. In order to foreclose any possibility of this conflict of interest occurring, the Department has proposed the definition of "advocate."

The limitation within the proposed definition is compatible with Minnesota Statutes, section 144.651, subdivision 30, which provides that "patients and residents [of health care facilities] shall have the right of reasonable access at reasonable times to any available rights protection services and advocacy services...." It is important to note that section 144.651 applies only to residential health care facilities and does not apply to all service systems for persons with mental retardation or related conditions. In particular, it does not govern the provision of case management. While the proposed definition does limit the role of advocate for purposes of case management related matters, it does <u>not</u> limit a residential health care facility's ability to afford reasonable access to advocacy services. Thus, the patient "bill of rights" does not limit the Department's ability to limit the advocate role in case management proceedings, particularly in light of the specific language of Minnesota Statutes, section 256B.092, subdivision 7, supra.

The other change to the definition of "advocate" is the addition of language which clarifies that the advocate speaks on behalf of the person with mental retardation or a related condition. Advocates assist the person by speaking on behalf of the person and representing the person's interests and rights and assisting the person in making choices. This definition is consistent with *Webster's Dictionary* definition as well as the ACDD definition of "advocacy" which refers to "speaking for, or on behalf of, a position, cause, or individual, especially when rights or interests are at risk or have been violated." *Standards for Services for People with Developmental Disabilities*, 1990, page 34.

The services of an advocate are particularly important where the person has no legal representative or if the person's legal representative lacks knowledge or expertise in the area of services to persons with mental retardation or related conditions. The proposed definition is reasonable because it permits designation of an advocate by the person or the person's legal representative for assistance in understanding and making informed choices in matters related to service needs. It is reasonable to require the designation to be in writing to provide evidence of who is authorized to act as an advocate and to avoid a potential conflict of interest in the event of the involvement of an unauthorized advocate. As discussed at length above, this avoidance of conflict of interest is consistent with insuring that the person's choices are voluntary.

Subpart 3. **Case management.** This definition is necessary to distinguish and separate case management administrative functions from case management service activities. In the 1991 session, Minnesota Statutes, section 256B.092 was amended to define case management administration and case management services separately. Section 256B.092, subdivision 1a now separates those responsibilities of case management that are administrative in nature from those that are direct service. Subdivision 1a(a) defines the administrative functions of case management to be provided or arranged for a person as including: (1) intake; (2) diagnosis; (3) screening; (4) service authorization; (5) review of eligibility for services; and (6) responding to requests for conciliation conferences and appeals.

Case management services are specified in Minnesota Statutes, section 256B.092, subdivision 1a(b), as: (1) development of the individual service plan; (2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options; (3) assisting the person in the identification of potential providers; (4) assisting the person to access services; (5) coordination of services; (6) evaluation and monitoring of the services identified in the plan; and (7) annual reviews of service plans.

These statutory changes were made to be consistent and in compliance with the federal standards. Administrative and service activities are separated in this way to clarify which activities are actual service activities and may be billed to medical assistance when the person is a waiver recipient under the community-based waivered services program. Medicaid will reimburse for case management service activities as defined under subpart 7. Although administrative activities can receive partial federal reimbursement, administrative activities are not billable as a service in the medicaid program.

This definition is reasonable because it distinguishes those functions of case management which are deemed to be administrative in nature from those which are considered services. Historically, a number of counties have been unclear about some aspects of reimbursement for case management responsibilities. Identifying in rule those functions which are considered to be administrative in nature is reasonable because it provides the counties with clarification on the issue of reimbursement.

The definition is reasonable because it is consistent with statute as well as federal standards. The Developmental Disabilities Assistance and Bill of Rights Act as amended in 1990 (P. L. 100-146) defines case management activities as:

> . . . priority area activities to establish life-long, goal oriented process for coordinating the range of assistance needed by persons with developmental disabilities and their families, which is designed to ensure accessibility, continuity of supports and services, and accountability and to ensure that the maximum potential of persons with developmental disabilities for independence, productivity, and integration into the community is attained.

42 U.S.C. §6001(16).

Subpart 4. **Case manager.** This subpart modifies the definition previously found in part 9525.0015, subpart 5. The change is principally a format change. The changes specify that the case manager is to work on behalf of the person and eliminates the references to the case manager's qualifications. It is necessary to reinforce the principle that the case manager's primary responsibility is to work on behalf of the person. It is reasonable to modify definitions to clarify and streamline rule language.

Subpart 5. **Commissioner.** The change in this subpart is a format change only. The term "commissioner" was previously defined in part 9525.0015, subpart 6. It is necessary and reasonable to move this term to part 9525.0004 without changing the definition because the rule has been reformatted and renumbered. The original need and reasonableness of this definition as presented by the Department in 1987 remains applicable.

Subpart 6. **County board**. The change in this subpart is a format change only. The term "county board" was previously defined in part 9525.0015, subpart 8. It is necessary and reasonable to move this term to part 9525.0004 without changing the definition to facilitate reformatting and renumbering of the rule. The need

and reasonableness of this definition as previously presented by the Department remains applicable.

Subpart 7. **County of financial responsibilty.** This subpart modifies the definition previously found in part 9525.0015, subpart 9. The change is principally a format change. The only language change is deletion of an obsolete statutory reference and replacement with the current statutory definition. The change is necessary to comply with Minnesota Statutes, chapter 256G, which governs the determination of residence and financial responsibility for the Minnesota human services system. It is reasonable to simply cite to Minnesota Statutes, section 256G.02, subdivision 4, to assure consistency with the statute and to avoid unnecessary duplication in the rule. Since the Unitary Residence and Financial Responsibility Act (Chapter 256G), governs the entire human services system, it is unnecessary to restate this definition in every rule because the sole governing statute is readily available to the public.

Subpart 8. **Department.** The change in this subpart is a format change only. The term "department" was defined previously in part 9525.0015, subpart 10. It is necessary and reasonable to move this term to part 9525.0004 without changing the definition because the rule has been reformatted and renumbered. The need and reasonableness of this definition as previously presented by the Department remains applicable.

Subpart 9. **Home and community-based waivered services.** This subpart modifies the definition previously found in part 9525.0015, subpart 11. The change deletes the list of the specific services and streamlines the definition by simply referring to Minnesota Statutes, section 256B.092, subdivision 4, which is the statutory authority for home and community-based services. It is reasonable to reference the statute which governs this specific type of service to facilitate compliance and promote consistency with the requirements of the statute and governing rule. This definition is further reasonable because it avoids unnecessary duplication and promotes brevity of the rule.

Subpart 10. **Host county.** This subpart modifies the definition previously found in part 9525.0015, subpart 12. This term is necessary to distinguish between the county which is financially responsible for provision of services to a person and the county in which the services are provided. It is reasonable to use the term "host county" to designate the county in which the services are provided because it is consistent with the manner in which the term is used in other department rules, is consistent with the common usage of the word "host", and is a term commonly used and understood by county boards and providers in Minnesota.

The addition of the second sentence in the definition is necessary to clarify the host county requirements which apply in situations where supported employment services are delivered in a county other than the host county. Questions surrounding this issue have arisen on a number of occasions in the past. Therefore, it is reasonable to clarify the definition in order to avoid future confusion and to facilitate compliance with the host county requirements.

Subpart 11. **Individual program plan or IPP.** This definition is necessary because it has meaning specific to parts 9525.0004 to 9525.0036. Minnesota Statutes, section 256B.092, subdivision 1b now requires that the individual service plan must identify whether there is a need for an individual program plan. Further, section 256B.092, subdivision 1c, requires that if the individual service plan identifies the need for individual program plans, the case manager shall assure that the individual program plans are developed by the providers.

It is necessary and reasonable to include the words "coordinated", "integrated", and "comprehensive" to convey the need to ensure that the individual program plan represents and incorporates the person's needs and approaches to meeting these needs into one document. By including this language, interdisciplinary team members will be made aware of the need to create a single plan that incorporates the expertise of various team members into a document that reflects consistency, integration, and comprehensiveness.

Item A: It is reasonable to require that the individual program plan is developed consistent with all aspects of the person's individual service plan because the individual service plan is the main document that identifies the individual service needs of the person and serves as basis for authorization of services.

Item B: It is reasonable to make a general reference to other state and federal laws which govern services to persons with mental retardation or related conditions, to facilitate compliance with the relevant regulations and applicable law governing services to persons with mental retardation or related conditions.

Item C: Item C is reasonable because it incorporates the requirements under Minnesota Statutes, section 256B.092, subdivision 1b(5) that the individual program plan must "be developed by the provider according to the respective state and federal licensing and certification standards...." It is reasonable to further require that the individual program plan be developed in consultation with the interdisciplinary team in

order to assure input and expertise of all relevant parties.

Subpart 12. **Individual service plan.** This definition was previously defined in part 9525.0015, subpart 14. It is necessary to modify the previous definition to assure consistency with the case management statute. The definition of individual service plan was amended in both the 1990 and 1991 sessions.

The definition given is reasonable because it is consistent with the requirements under Minnesota Statutes, section 256B.092, subdivision 1b, in particular subitem (4), which provides that the individual service plan must "identify specific services and the amount and frequency of the services to be provided to the person based on assessed needs, preferences, and available resources."

It is reasonable to refer to the components of the individual service plan required under part Minnesota Statutes, section 256B.092 because that section governs the development of the individual service plan. The need and reasonableness for this subpart is specified further in part 9525.0024.

Subpart 13. **Informed choice.** It is necessary to define the term "informed choice" because federal law requires that as part of the service planning and screening process, the person be afforded the opportunity to make an informed choice among feasible services available to them. In particular, Code of Federal Regulations, title 42, section 441.303 requires that eligible persons with mental retardation or related conditions must be given the opportunity to make an informed choice between ICF/MR and home and community-based services.

This definition is reasonable because it is consistent with the principles of informed choice commonly accepted in the field of developmental disabilities. It is also consistent with the definition and information contained in the Department's brochure for guardians or persons interested in accessing home and community-based waivered services for themselves or their family members, which includes a discussion on informed choice about case management services. With respect to the case manager's responsibility for informed choice, the brochure states:

> If it is determined at the screening meeting that the person with mental retardation or a related condition is in need of the level of care provided by an ICF/MR, they or their legal representative, if any, will be asked to make an informed choice of which services they would like to receive. This means they are:

> ▸Informed by the case manager and understand any feasible alternatives available under the waiver or in an ICF/MR and given the choice among those alternatives; and
> ▸Given the choice by the case manager at the time of screening of either ICF/MR or waivered services; and
> ▸Making a voluntary decision.

Waivered Services Program for Persons with Mental Retardation and Related Conditions, Title XIX Home and Community-Based Services, Arc Minnesota and Minnesota Department of Human Services, November 1992, page 8 (emphasis added).

Further, the *Developmental Disabilities Act* of 1990 states:

> [I]t is in the national interest to offer persons with developmental disabilities the opportunity, to the maximum extent feasible, to make decisions for themselves and to live in typical homes and communities where they can exercise their full rights and responsibilities as citizens.

42 U.S.C. §6000(a)(9).

Items A through C are reasonable because, in the social service setting, informed choice means that the person is to be aware of all of the service alternatives which are available, to choose the services the person prefers, or to choose none of them. The purpose of requiring informed choice is to assure that the person has first been made aware of their choices to facilitate choices that are in the best interest of the person. While some persons with mental retardation or related conditions can be made aware of their alternatives by simply having the alternatives explained to them, other persons may require more assistance in becoming aware of their alternatives. For example, it is usually necessary to take a person to a residential site to allow the person to actually experience the alternatives in order for the person to understand. Therefore, it is reasonable that the definition include the component that the person must be familiarized with the alternatives in order to make an informed choice.

Item A: In item A, informed choice among feasible alternatives means that the person will be made aware of available alternatives and then makes a choice among them. It is reasonable to inform the person that preference for a particular alternative is not a guarantee if that the person's choice is not available.

Item B: Item B is reasonable because it informs the person that while certain alternatives may not currently be available, such

alternatives may become available in the future and therefore, should be considered when making an informed choice.

Item C: Item C is reasonable because after becoming familiarized with the alternatives, ultimately the person does have the right to refuse an alternative.

With regard to an informed choice among feasible alternatives, the aforementioned brochure states:

> To make an informed choice of services, the person or their legal representative must be aware of and familiar with service alternatives and choose the alternative preferred. They may also choose an alternative to be developed in the future or refuse all alternatives.

Waivered Services Program for Persons with Mental Retardation and Related Conditions, Title XIX Home and Community-Based Services, Arc Minnesota and Minnesota Department of Human Services, November 1992, page 8.

Subpart 14. **Interdisciplinary team.** This subpart modifies the definition previously found in part 9525.0015, subpart 15. The change is principally a format change. The change is necessary to clarify which service providers are required to participate in the interdisciplinary team process. During the advisory committee process, a number of committee members expressed concern that the previous definition was vague with respect to which service providers are required to participate in the interdisciplinary team. Some members expressed concern that because the previous definition was vague, it could be implied that all providers of service of any type to the person must be involved in the interdisciplinary team. In particular, these members were concerned that the previous definition could be read to require medical and dental professionals to participate in the interdisciplinary team meetings. Such a requirement would be costly and difficult to coordinate. The change to this definition is reasonable because it clarifies that participation is required only by representatives of those providers of services that are relevant to the needs of the person as specifically stated in the person's individual service plan. For example, if a person has specific medical needs but these needs are being monitored by a health care professional associated with the service provider, that individual could represent the medical profession (or the person's physician) in the interdisciplinary team.

Subpart 15. **Intermediate care facility for persons with mental retardation or ICF/MR.** The change in this subpart is a format

change only. This term was previously defined in part 9525.0015, subpart 16. It is necessary and reasonable to move this term to part 9525.0004 without changing the definition because the rule has been reformatted and renumbered. The need and reasonableness for this definition as previously presented by the Department remains applicable.

Subpart 16. **Least restrictive environment.** This subpart modifies the definition previously found in part 9525.0015, subpart 17. The changes streamline the rule by eliminating the standards previously delineated in items A through F. The revised definition is reasonable because it is consistent with the principles currently supported by experts in the field of developmental disabilities. The definition is further reasonable because it incorporates the key components into one concise sentence which contributes to the brevity of the rule.

Subpart 17. **Legal representative.** This subpart modifies the definition previously found in part 9525.0015, subpart 18. The changes are necessary to eliminate unnecessary and duplicative language, and to clarify the delegation of legal representation on the basis of temporary unavailability.

It is reasonable to delete references to "persons with or who might have mental retardation or a related condition" because the phrase is no longer necessary. The term "person" is now defined in part 9525.0004 and incorporates the definitions of "person with mental retardation," "person with a related condition," and "person who might have mental retardation." Accordingly, parts 9525.0004 to 9525.0036 simply reference the term "person" throughout. The need and reasonableness of the term "person" is specified further in subpart 20 below.

Since the promulgation of parts 9525.0015 to 9525.0165 in 1987, the Department has become aware of a number of situations in which the legal representative has become temporarily unavailable, for example, in cases of incapacitation due to hospitalization or incarceration. In such cases, the issue has arisen of who is authorized to make decisions on the person's behalf, that is, who is to act as the legal representative when screenings and other such decision-making activities must be conducted during the legal representative's absence. Minnesota Statutes, section 524.5-505, which provides that:

> A parent or guardian of a minor or incapacitated person, by a properly executed power of attorney, may delegate to another person, for a period not exceeding six months, any powers regarding care, custody, or property of the minor or ward, except the power to consent to marriage or adoption of

a minor child.

This provision is reasonable because it informs those governed by the rule about how such cases of temporary unavailability will be handled. Most significantly, it assures that the needs and best interests of the person with mental retardation or a related condition continue to be met, notwithstanding the unavailability of their legal representative.

Subpart 18. **Overriding health care needs.** This definition is necessary to facilitate compliance with statute. Minnesota Statutes, section 256B.092, subdivisions 1a and 7 require the involvement of health care professionals in service planning for persons with overriding medical needs. Because the statute established specific requirements in those cases where the person has overriding health care needs, the meaning of this term is integral to the understanding of those rule parts which govern the actions of the screening and service planning team; in particular, part 9525.0016, subparts 7 and 8 and part 9525.0024, subpart 2. Further, during the committee process, a number of members urged that the term "overriding health care needs" be specifically defined in order to preclude the interpretation that a registered nurse be required to participate in any screening that involves a person with health care needs. The definition given is reasonable because it clarifies that the meaning of overriding health care needs for purposes of this rule is confined to those cases that require specialized or intensive medical or nursing supervision as well as awareness and adaptation on the part of the service providers in order to accommodate the health and safety needs of the person. This definition was developed in consultation with The Minnesota Nurses Association. This clarification is reasonable to avoid misinterpretation and unnecessary expenditure of resources.

Subpart 19. **Person.** This definition is necessary to define a term that is used throughout parts 9525.0004 to 9525.0036. The term "person" serves as an abbreviation throughout the rule parts for a "person with mental retardation," a "person with a related condition," or a child under the age of five who has been determined eligible for case management under parts 9525.0004 to 9525.0036. The term "person with mental retardation" is defined in subpart 20 and the term "person with a related condition" is defined is subpart 21. It is reasonable to use an abbreviated form of the terms throughout the rule parts in order to avoid unnecessary duplication. Use of the term "person" is further reasonable because it places the emphasis on the person receiving services rather than the person's disability. This is consistent with the current philosophy of case management that the needs and preferences of the person is the main emphasis in the provision

of case management.

Subpart 20. **Person with a related condition.** This subpart modifies the definition previously found in part 9525.0015, subpart 20, item C. The term was previously defined as a part of the definition of "mental retardation"; for purposes of parts 9525.0004 to 9525.0036, it is now defined as a separate term.

The changes in this definition are necessary to be consistent with statute and the Code of Federal Regulations. Minnesota Statutes, section 252.27, subdivision 1a defines the term "related conditions." Section 252.27 has been amended since the promulgation of parts 9525.0015 to 9525.0165 and now includes Prader-Willi syndrome as a related condition, when the person's functional diagnosis also meets the other requirements under this definition. The statutory definition also now provides that the related condition "requires treatment or services similar to those required for persons with mental retardation."

It is necessary to define this term because "related conditions" has a meaning integral to the understanding of the rule parts. The definition given is reasonable because it simply references Minnesota Statutes, section 252.27, subdivision 1a. It is reasonable to cross-reference the statutory definition to avoid unnecessary duplication and to assure consistency with statute. This is particularly important in the case of the definition of "related conditions" because it is likely that the definition under section 252.27 may be amended during the 1993 or subsequent legislative session. Accordingly, referencing the statute will assure that the rule remains consistent with the statutory requirements and will not soon become obsolete.

As stated above, parts 9525.0180 to 9525.0190, which govern the diagnosis of related conditions are being repealed and the diagnostic requirements incorporated into parts 9525.0004 to 9525.0036. It is reasonable to consolidate the diagnostic requirements for mental retardation and related conditions into one governing rule because parts 9525.0004 to 9525.0036 apply to case management for persons with mental retardation and for persons with related conditions. Consolidating these diagnostic requirements eliminates unnecessary duplication and streamlines the diagnostic process.

Subpart 21. **Person with mental retardation.** This subpart modifies the definition previously found in part 9525.0015, subpart 20. The definition contained in part 9525.0015, subpart 20, included the definition of "related conditions" under item C. The definition of "related conditions" is deleted from this subpart and moved to subpart 22 as a separate definition. The

changes in this definition incorporate the additional diagnostic component of substantial limitations in present functioning. This addition is necessary to assure consistency with federal diagnostic standards. According to the American Association on Mental Retardation (AAMR), "mental retardation" is defined as the following:

> Mental retardation refers to substantial limitations in present functioning. It is characterized as significantly subaverage intellectual functioning, existing concurrently with related disabilities in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

Mental Retardation: Definition, Classification and Systems of Supports, 9th Edition, 1992, page 5.

According to the AAMR, mental retardation is defined as fundamental difficulty in learning and performing certain daily life skills. The person's capabilities in which there must be a substantial limitation are conceptual, practical, and social intelligence. In its 1992 revision of its manual, the AAMR adopts a functional model as the conceptual basis for the current definition of mental retardation. The revised AAMR definition recognizes the importance of the environment and its impact on functioning. It also places greater emphasis on adaptive skills. In particular, the revised definition emphasizes the relationship between specific disabilities in intellectual and adaptive skills, environmental modifiers of the impact of these deficits, and the level of support needed to improve functioning in the community. It is reasonable to update state definitions to assure consistency with federal and state-of-the-art standards in the field of mental retardation.

Subpart 22. **Provider.** The change in this subpart is a format change only. The term "provider" was previously defined in part 9525.0015, subpart 23. It is necessary and reasonable to move this term to facilitate the format change. The need and reasonableness for this definition as previously presented by the Department remains applicable.

Subpart 23. **Public guardian.** This definition is necessary to implement statutory requirements. Minnesota Statutes, section 256B.092, subdivision 7, requires that:

> County social service agencies may contract with a public or private agency or individual who is not a service provider for the person for public guardianship

> representation required by the screening or individual service planning process. The contract shall be limited to public guardianship representation for the screening and individual service planning activities.

Part 9525.0016 refers to the screening team responsibilities and part 9525.0024 governs the individual service planning development process. The meaning of "public guardian" is particularly important to these parts. It is reasonable to simply refer to Minnesota Statutes, section 252A.02, subdivision 7 because Chapter 252A governs public guardianship. Simply referencing the statutory definition is reasonable in order to avoid unnecessary duplication and promotes brevity of the rule.

Subpart 24. **Qualified mental retardation professional.** This subpart modifies that definition previously found in part 9525.0015, subpart 26. The change is principally a format change. The change is necessary to assure consistency with federal regulations. The definition of "qualified mental retardation professional" contained in the Code of Federal Regulations was amended since the original promulgation of parts 9525.0015 to 9525.0165, and is now found in Code of Federal Regulations, title 42, section 483.430. Since the definition contained in this rule cites to the federal definition, it is reasonable to reflect the change in this subpart. The need and reasonableness for this definition as otherwise previously presented by the Department remains applicable.

Subpart 25. **Residential program.** This subpart replaces the definition previously found in part 9525.0015, subpart 30. The change is necessary to be consistent with terminology currently used in other Department rules as well as human services statutes. Minnesota Statutes, chapter 245A, which was enacted in 1987, governs the licensure by the Commissioner of residential and nonresidential programs. The term "residential program" is defined in section 245A.02, subdivision 14. It is necessary to define the term because it used throughout the rule parts. It is reasonable to simply cite the statutory definition to avoid unnecessary duplication and promote brevity of the rule.

Subpart 26. **Screening team or service planning team.** This subpart modifies the definition previously found in part 9525.0015, subpart 31. The changes are necessary to assure consistency with the case management statute. Minnesota Statutes, section 256B.092, subdivision 7, provides that:

> The screening team shall consist of the case manager for persons with mental retardation or related conditions, the person, the person's legal guardian or conservator, or the

> parent if the person is a minor, and a qualified mental retardation professional, as defined in the Code of Federal Regulations, title 42, section 483.430, as amended through June 3, 1988.

The definition given is reasonable because it includes those members required by subdivision 7. Minnesota Statutes, section 256B.092, subdivision 7, further provides that, "Nothing in this section shall be construed as requiring the screening team meeting to be separate from the service planning meeting."

It is reasonable to include reference to the term "service planning team" as well as "screening team" to clarify that according to statute, they are the same team. It is reasonable to required that screening members have no direct or indirect service provider interest to facilitate objective planning that is in the best interest of the person and to avoid any potential conflict of interest.

The last sentence of this definition is necessary and reasonable to clarify that statute requires the case manager to be a member of this team and therefore, the case manager is not deemed to have a direct or indirect financial interest for purposes of the screening or service planning team only. This is important as distinguished from the definition of advocate under subpart 3 which does include the case manager as one who is limited from acting as the formal advocate. See subpart 3 above for the need and reasonableness of the definition of advocate.

Subpart 27. **Semi-independent living services.** This subpart is necessary to define one of the service areas identified and discussed in parts 9525.0004 to 9525.0036. It is reasonable to simply cross reference the definition contained in Minnesota Statutes, section 252.275, subdivision 1 because section 252.275 governs the provision of semi-independent living services.

Subpart 28. **Training and habilitation services.** This subpart modifies the definition previously found in part 9525.0015, subpart 33. The changes are necessary to streamline the rule and reduce unnecessary duplication. It is reasonable to simply cross reference part 9525.1500, subpart 36 because parts 9525.1500 to 9525.1630 govern the licensure of training and habilitation services.

9525.0025 [See repealer]. The deletion of this part is essentially a format change. The applicability and purpose provisions have been moved to part 9525.0008 and modified as

indicated below. The deletion of this rule part is reasonable to accomplish the format change.

9525.0008 APPLICABILITY AND PURPOSE.

Subpart 1. **Applicability.** The change in this subpart is a format change only. The applicability provision was previously found at part 9525.0025, subpart 1. It is reasonable to move this provision to accomplish the format change. The need and reasonableness for this subpart as previously presented by the Department remains applicable.

Subpart 2. **Purpose.** This subpart modifies the provision previously found in part 9525.0025, subpart 2. The changes are necessary to provide those governed by parts 9525.0004 to 9525.0036 with a general overview of the essential need for, purpose and expected outcomes of case management, as well as to simplify and streamline the rule. This subpart is necessary to inform the public of the purpose for promulgation of the rule parts and reasonable expectations of the consumer from the case management system.

Items A through C are reasonable because they identify the outcomes and most important aspects of case management for purposes of parts 9525.0004 to 9525.0036. The Developmental Disabilities Act as amended in 1990, defines case management services to include "goal-oriented process for coordinating the range of assistance needed. . .designed to ensure accessibility, continuity of supports and services, and accountability."

This subpart is necessary to implement the statutory directive to emphasize outcomes in rules. Minnesota Statutes 1991, section 256E.05, subdivision 1a, provides that:

> The commissioner may review social services administrative rule requirements and adopt amendments under chapter 14 to reduce administrative costs and complexity by eliminating unnecessary or excessive paperwork, simplifying or consolidating program requirements, or emphasizing outcomes rather than procedures. In determining the reasonableness of the requirements, the commissioner shall consider the needs the service was developed to address and the adequacy of the state and local funding available to provide the service.

The implementation of this statutory provision is referred to as the mandates reform effort. In addition to the effort to simplify rules and eliminate unnecessary rule requirements, the

Department is striving to emphasize outcomes rather than procedures in rules where appropriate.

Using an outcomes approach is reasonable because it is consistent with the professional literature related to services to persons with mental retardation or related conditions; the Governor's Executive Order 91-12 to simplify and eliminate prescriptive rule requirements; the Department's policy direction based on the intent of Minnesota Statutes, section 256E.081, subdivision 3; and improved service delivery. One of the major reasons for using an outcomes-based approach is to improve service delivery allowing counties and individual case managers more flexibility and greater ability to provide or arrange for the provision of services to their clients. Service needs of individuals differ markedly. The case manager is in the best position to determine the most effective approach to meet the person's needs. Requiring outcomes with specified goals to reach these outcomes rather than specific processes, allows the case manager to select the approach most suited to the individual's needs. Accordingly, an outcomes focus provides an opportunity to improve service delivery to the person. Similarly, a county is in the best position to know county circumstances, their clients' needs, and the resources available to meet these needs. Therefore, it is reasonable to focus on desired outcomes because this allows the county the flexibility to select the approach most suited to the county's circumstances.

In developing the goals proposed in subpart 3, the Department reviewed literature on service goals, desired outcomes, and outcome indicators for services to persons with mental retardation or related conditions. In 1993, the ACDD plans to adopt outcome-based performance measures to replace the process-oriented standards which have formed the basis of the Council's quality assessment/accreditation process for forty years.

The ACDD is a recognized leader in defining quality standards for programs and facilities serving persons with disabilities. For example, ACDD standards served as a basis for the initial federal ICF/MR regulations issued in 1974 as well as the subsequent revisions of those regulations. Further, several states require provider agencies to achieve Council accreditation as a condition of receiving funding to serve persons with disabilities.

Historically, ACDD standards have been process-oriented. However, according to a bulletin from the National Association of State Mental Retardation Program Directors:

> At the same time, a growing number of questions have been raised concerning the value of the Council's process-

> oriented standards and the alignment of such standards with the ongoing shift from program-centered service delivery models to the person-centered support paradigm. While assuring that services are meeting accepted standards of practice is one indicator of quality, critics of the current approach contend that focusing solely on process often results in paying too little attention to whether desired outcomes are being achieved. Process-oriented standards also are seen as contributing to the "over-professionalization" of service delivery and out-of-touch with underlying service delivery trends.

The Community Services Reporter, Bulletin No. 92-11, May 22, 1992, National Association of Mental Retardation Program Directors, pages 1-2.

The ACDD initially developed outcome-based performance measures in response to a request from Illinois, in evaluating the State's Community Integrated Living Arrangement Program. Since that time, the ACDD has circulated successive refinements of these outcome standards for comments from persons with disabilities, providers, state and federal agencies, families, and professionals. These outcome standards are undergoing additional field testing to ensure that they are both valid and reliable.

The ACDD's outcome-based performance measures focus on what the service or support did for the person. The ACDD specified 30 measures of this across ten dimensions which are regarded by the ACDD as a potentially useful framework for the enhancement of services and supports to persons with disabilities. The ACDD outcome-based performance standards measure the following ten outcome dimensions: 1) social inclusion; 2) relationships; 3) rights; 4) individual control; 5) satisfaction; 6) privacy; 7) environment; 8) health; 9) security and economic well-being; and 10) growth and development. Each of these ten outcomes is written in language that stresses the outcome for the person. For example, the social inclusion outcome is phrased as: "People perform different social roles and participate in the life of the community."

The ACDD proposed outcome-based performance measures include a system for measuring whether or not a particular outcome is being achieved. For example, the social inclusion outcome would be measured by answering the following questions:

> 1) What does the person do when he or she shares in the life of the community?
> 2) How often does the person participate in the life of the community?

3) Is this type and frequency of participation satisfactory to the person?
4) If not, why is the participation not satisfying?
5) If the person is not satisfied with the participation in the community, what is the agency doing to remove barriers to participation?

Item A: Item A is necessary to assure that access to needed services and supports is an integral part of the provision of case management. The Accreditation Council on Services for People with Developmental Disabilities (ACDD), states that:

> The service system should be designed so that people in need of services are made aware of, helped to locate, and given the opportunity to obtain the services they need.

Standards and Interpretation Guidelines for Services for People with Developmental Disabilities, 1990, page 75.

The significance of access to services is further illustrated in the following comments of the ACDD:

> Individuals, their families, and concerned others should have access to accurate and current sources of information and to referral services related to available generic and specialized resources. The agency should use this information to assist individuals, family members, program coordinators, and counselors to identify needed resources. This information should be presented in a manner easily understood by the individual and his or her family.

Id. at 73.

This item is further reasonable because it is consistent with the requirement of part 9525.0024, subpart 6, under which it is the responsibility of the case manager to assist the person in accessing selected services by being responsive to the person's requests for locating and obtaining services.

Item B: Under item B, coordinated services and supports are necessary to best meet the person's individual needs. According to the ACDD:

> The service network should be able to provide individuals with what they need when they need it. In order for this to happen, the delivery of services must be systematic, coordinated, and integrated within each agency and among the specialized agencies and generic service providers within the community.

Id. at 61.

The importance of coordinated services and supports is evidenced in the following comment by the ACDD:

> Each agency that offers one or more program components should make information available about the services that it contributes to the total service system, including the scope and limitations of those services. Each agency should be willing to modify its services in response to individual and family needs, to the roles of other agencies, and to the community planning processes. While one agency is not expected to provide all the services needed by any one individual or family, every agency should know where services can be obtained and cooperate in efforts to make all requisite services available and accessible through the service network.

Id. at 62.

It is reasonable to provide that the services and supports are to be cost-effective in order to promote prudent use of public funds and to provide a means of accountability.

Item C: Continuity of services and supports is another component of case management that is necessary to best meet the individual needs of the person receiving services. Continuity of services, according to David Moxley, in his book, *The Practice of Case Management* (Sage Publications, 1989), means both continuity among services and supports over time and continuity at any given point in time among the service system providers.

The importance of continuity of services is recognized under the Developmental Disabilities Act (P. L. 100-146), which defines case management services as:

> ...priority area activities to establish life-long, goal oriented process for coordinating the range of assistance needed by persons with developmental disabilities and their families, which is designed to ensure accessibility, <u>continuity of supports and services</u>, and accountability and to ensure that the maximum potential of persons with developmental disabilities for independence, productivity, and integration into the community is attained.

42 U.S.C. §6001(16) (emphasis added).

Item D: Item D is necessary to relate the desired outcomes of case management identified in this subpart to the specific goals

identified under subpart 3. It is important that, as a measure of outcome, goals and the success in reaching such goals be considered. It is reasonable to state this relationship to avoid misinterpretation.

Subpart 3. **Goals.** This subpart is necessary to further implement the statutory directive to emphasize outcomes in rules. This subpart specifies the goals for persons with mental retardation or related conditions who are receiving supports and services as arranged through case management. This subpart is necessary in order to inform persons receiving case management, counties, and service providers, of the goals for persons receiving services. This subpart is reasonable because it provides a framework of goals which are consistent with the Minnesota vision upon which the provision of case management to persons with mental retardation or related conditions should be based.

The advisory committee reached a consensus that the desired goals should be those specified in items A through D. Items A through D represent the key goals for persons with mental retardation or related conditions who are provided case management pursuant to parts 9525.0004 to 9525.0036.

Item A: This goal is reasonable because case management and all services provided to persons with mental retardation or related conditions should be provided on the basis of the individual and unique needs of the person. Each person with mental retardation or a related condition has their own unique needs and preferences, just as any other member of the community. Specifically, each person with a developmental disability has a unique history, personal integrity, and cultural background. Services designed for persons must recognize and respect the individuality of the person. The 1992-1993 Minnesota State Plan for persons with mental retardation and related conditions identifies the following value:

> Services provided to Minnesotans with developmental disabilities are based on the following values: All citizens, including those with the most severe impairments, are unique human beings with value and dignity and can contribute in important ways to life in the communities of Minnesota.

Id. at 2.

Case management is not to be designed and delivered as a general service which is directed at a disability population. Just as needs of persons without disabilities within a community vary greatly, so do needs of individuals with mental retardation or

related conditions. In its 1990 *Standards and Interpretation Guidelines for Services for People with Developmental Disabilities*, the ACDD stresses the importance of service providers cooperating with individuals, families, guardians, and advocates to maintain personal and informal records that document personal history and identity.

Item B: This goal is reasonable because the affirmation and protection of the person's civil and legal rights is one of the primary functions of the case manager and is at the very heart of the purpose of case management. The *Developmental Disabilities Act* as amended in 1990 states:

> [I]t is in the national interest to offer persons with developmental disabilities the opportunity, to the maximum extent feasible, to make decisions for themselves and to live in typical homes and communities where they can exercise their full rights and responsibilities as citizens.

42 U.S.C. §6000 (a)(9).

Section 6009 of the Act goes on to identify Congressional findings regarding rights of the developmentally disabled, describing rights to appropriate treatment, services, habilitation, and requires that services must meet minimum standards described in this section. Section 6009 continues:

> The rights of persons with developmental disabilities described in findings made in this section are in addition to any constitutional or other rights afforded to all persons.

42 U.S.C. §6009.

Similarly, the ACDD defines "affirmation of rights" as:

> [H]elping people with developmental disabilities exercise their human civil rights. This may include activities such as family and community education to increase awareness of individual rights, specific advice to the individual about ways to exercise his or her rights, and support of self-advocacy.

Standards and Interpretation Guidelines for Services for People with Developmental Disabilities, 1990, page 28.

The ACDD further defines "protection of rights" as:

> [E]nsuring that an individual's rights are not denied. This may include prevention of abuse, neglect or exploitation, and assistance in obtaining public education, social security benefits, or admission to a hospital as well as active intervention in social programs or legal processes.

Id.

Persons with mental retardation or related conditions have the same rights as all citizens, including such rights as: the right to life, the right to own and dispose of property, freedom of association, access to educational and employment opportunities and health care resources, the right to vote, the right to liberty, the right to consent to or refuse treatment, the right to privacy, freedom of religion, the right to express sexuality, the right to marry and have children, and the right to participate as an active and contributing member of the community.

Persons with mental retardation or related conditions who are at the age of majority are assumed capable of exercising individual rights, unless a legal representative has been appointed to represent the individual's interests and to protect their civil rights. It is reasonable to inform those governed by parts 9525.0004 to 9525.0036 that case management is premised upon the principles of affirmation and protection of the person's rights, to ensure that persons with mental retardation or related conditions who may need some degree of guidance are not denied the liberty to exercise their rights to the extent they are able.

Item C: The goals delineated in subitems 1 through 5 are reasonable because they specify key aspects of services for persons with developmental disabilities. The principles of community inclusion, integration, self-sufficiency and least restrictive environment are integral to the current state of the service delivery system. *The Developmental Disabilities Act* of 1990 states:

> The purposes of this chapter are to:
> (1) ...to assure that all persons with developmental disabilities receive the services and other assistance and opportunities necessary to enable such persons to achieve their maximum potential through increased independence, productivity, and integration in the community;...(5) promote the inclusion of all persons with developmental disabilities, including persons with the most severe disabilities.

42 U.S.C. §6000.

The three year plan of the Governor's Planning Council on Developmental Disabilities 1992 to September 1994 states:

> During the 1980's, we discovered the worth of integration and began to apply it. . .The challenge for us during the next decade is to build truly inclusive communities.

Id. at 9.

The ACDD defines "community integration" as: "arrangements that enable individuals to live, work, learn, and play side by side in the community with people who do not have disabilities." *Standards and Interpretation Guidelines for Services for People with Developmental Disabilities*, 1990, page 15.

Item C is reasonable because its requirements are consistent with federal and state law. The fact that the law emphasizes community integration is evident in the following federal and state laws. For instance, Section 504 of the *Rehabilitation Act of 1973* (Public Law 93-112), prohibits segregation from the rest of society unless the necessity for segregation can be proved.

Further, the *Developmental Disabilities Assistance and Bill of Rights Act* (42 U.S.C. §§6000 et. seq.)is aimed at enabling persons with developmental disabilities to achieve their maximum potential through three key concepts, which have become goals for services to persons with developmental disabilities: independence, productivity, and integration into the community. The Act provides funds for the developmental disabilities planning council and a protection and advocacy system in each state, and a network of university-affiliated programs across the country. The work of the developmental disabilities councils is supported by small grants to states, which may be used to fund activities to support improvements in the service system. Funds are also provided for protection and advocacy services, which represent persons with developmental disabilities in areas such as special education, guardianship, abuse and neglect, transportation, housing, and employment discrimination.

The magnitude of the principle of community integration is also evident in the *Americans with Disabilities Act of 1990* (ADA) 42 U.S.C. §§12101 et. seq. This comprehensive civil rights legislation creates sweeping protection of rights in the areas of employment, public accommodations, transportation, and telecommunications for persons with disabilities, including developmental disabilities. For example, private entities such as movie theatres, day care centers, schools, hotels,

restaurants, grocery stores, libraries, beauty parlors, and numerous other businesses and facilities will be required to make their building accessible for persons with developmental disabilities. Employers also must make reasonable accommodation for persons with disabilities, through such means as restructuring jobs, modifying facilities, or supplying interpreters and readers. The ADA will greatly enhance the ability of persons with developmental disabilities to live, work, recreate, and travel in the community. See, *Americans with Developmental Disabilities, Policy Directions for the States*, Report of the Task Force on Developmental Disabilities, National Conference of State Legislatures, 1991.

Minnesota Statutes, section 256B.092, subdivision 8(c), mandates that the screening team shall "identify the level of services appropriate to maintain the person in the most normal and least restrictive setting that is consistent with the person's treatment needs." Further, Minnesota Statutes, section 256E.08, subdivision 1, requires the provision of services "that assist each person to function at the highest level of independence possible for the person, preferably without removing the person from home."

It is reasonable to include the goal of promoting social relationships, natural supports, and participation in the life of the community because these are key elements of normalization. The ACDD defines "social relationships" as: "that network of people - family, friends, neighbors, co-workers, peers - who provide love, acceptance, validation, support, and emotional closeness to the individual." *Standards and Interpretation Guidelines for Service for People with Developmental Disabilities*, The Accreditation Council on Services for People with Developmental Disabilities, 1990, page 15.

With respect to community integration, the ACDD stresses in its guidelines that services should: 1) support the individual in forming and maintaining relationships with friends, neighbors, and co-workers, including people who do not have disabilities; and 2) enable individuals to participate in community, social, civic, religious, charitable, recreational, and other activities according to their interests and preferences.

Age-appropriateness is another key element of the concept of normalization. The ACDD characterizes the significance of age-appropriateness in its following remarks:

> Individuals should be seen first as people and then as people with disabilities. Therefore, it is important to

> strengthen those qualities of behavior and dress and make use of those settings, activities, and possessions that are natural for persons of the same age who do not have disabilities.

Id. at 49.

With regard to the provision of habilitation services, the ACDD guidelines specify that training content, methods, and materials should be culturally normative and age appropriate to enhance the value of the individual when viewed by their peers who do not have disabilities.

Balancing safety and opportunities are essential principles that must be considered in the design and provision of services to persons with mental retardation or related conditions. According to the ACDD, safety is one of the primary keys to the person's ability to live an independent life. In its guidelines, the ACDD stresses that services should assist the individual to meet their own safety needs.

The ACDD illustrates the importance of decision-making to the principle of consumer empowerment in its following guidelines:

> Consumer empowerment is based on the belief that when decisions are made that affect the lives of individuals and their families, the decision-making authority rests with the individual and the family. To ensure that decisions are relevant and workable, the agency provides the individual with the opportunity to learn decision-making skills and various opportunities to use those skills in all aspects of day-to-day living. If an individual is not able to make an informed decision and does not understand the consequences of the decision, then the individual should learn to exercise choice in other situations that are appropriate to his or her level of functioning. A commitment to consumer empowerment means that individual wishes and desires are viewed as important and those individuals participating in services have a leadership role in service design and delivery.

Id. at 13.

The goals specified in item C are also similar to those service outcomes developed by the Office of Research and Evaluation of the Ramsey County Human Services Department. The Office of Research and Evaluation prepares an annual report which summarizes findings regarding all programs included in the Ramsey County's Human Services Department's evaluation and monitoring

systems, including services for persons with developmental disabilities. Ramsey County has identified three major outcomes for its developmental disabilities services: 1) Maintain clients in the least restrictive community living; 2) Achieve developmental growth and stability; and 3) Enhance self-sufficiency and vocational potential.

Item D: It is necessary to include the goals relating to services and supports for the family because it is a commonly-accepted that the family is the primary social environment for children with mental retardation or related conditions and the basis for lifelong personal relationships for adults. The ACDD defines "family support services" as "the range of resources provided to the family, whether a single family member or an extended family, to increase its capacity to support the individual with a developmental disability in a family unit." *Id.* at 22.

According to the ACDD in its 1990 guidelines:

> Support services should help to alleviate stress in the family and enable families to function well while retaining their natural autonomy. Education can increase family capabilities and autonomy. The provision of family education recognizes the family as primary asset in the life of an individual with a developmental disability. Family education builds on those positive contributions and capabilities to support and nurture all family members.

Standards and Interpretation Guidelines for Services for People with Developmental Disabilities, Accreditation Council on Services for People with Developmental Disabilities, 1990, page 23.

Further, according to the National Conference of State Legislatures (NCSL):

> [F]amilies need services and support systems that are comprehensive, flexible, well-coordinated, family-centered, community-based, and integrated within existing community networks. Services should also enhance a family's understanding of and response to its child's disability and available resources.

Americans with Developmental Disabilities-Policy Directions for the States, Report of the Task Force on Developmental Disabilities, 1991, page 8.

In its recommendations for state action, the NCSL Task Force on Developmental Disabilities made the following recommendations in the area of family support:

> (a) Create and fund family support programs for those families who provide care at home for their children with developmental disabilities, adhering to the following guiding principles:
> * The program should support the family rather than the service provider.
> * All children, regardless of disability, have the right to grow up with a family, biological or otherwise, and need enduring relationships with adults.
> * The role families play in providing care at home must be recognized and supported so that family members are enabled and empowered to make informed decisions.
> * Means for supporting family efforts should build on existing support network and natural support within the community and should be culturally sensitive.
> b) Provide flexible programs to meet the needs of individual families, recognizing that their needs change over time.
> c) Require coordination of all family support-related activities undertaken by state agencies, such as departments of developmental disabilities, education, human resources, public welfare, and mental health.
> d) Use all public and private sector resources available to families, including government agencies, private employers, and private health insurers.
> e) Ensure adequate training for persons who provide family support.
> f) Design all family support initiatives to promote the integration of persons with disabilities into the community.
> g) Monitor the quality and effectiveness of all service programs through systematic reviews, which should include input from consumer families.
> h) Define family support as a benefit program that is not included as income for purposes of state taxation.
> i) Provide independent living and work training to youth with disabilities to facilitate transition into adulthood and to promote independence.

Id. at 13-14.

Similarly, the National Commission on Children, it its Final Report, identified principles which form the foundation of the Commission's specific proposals for public and private sector policy and program development. The following principles specifically addressed the importance of the family:

> ▸The family is and should remain society's primary institution for bringing children into the world and for supporting their growth and development throughout childhood.
> ▸Community institutions . . .have an important role in creating an environment that is supportive of parents and children.

Beyond Rhetoric-A New American Agenda for Children and Families, Final Report of the National Commission on Children, 1991, Executive Summary, pages xix-x.

With respect to the development of a child in the context of the family, the Commission on Children comments further that:

> Development is more than physical growth. It is the process through which children mature socially, emotionally, intellectually, and morally; they learn right from wrong; and they acquire critical knowledge and skills. Development depends upon trusting and loving relationships, the first and most fundamental of which is between children and their parents. The enduring support that comes from strong, mutual, emotional bonds between parents and their children is the foundation for all subsequent development and human relationships.

Id. at 40.

The importance of the family component of services is further illustrated in the book *Strengthening Families*, which offers a basic value position in relation to children and families: "A central goal of public policy and program development is to enhance human development through community." The authors stress that the aim of public policy should be to enhance human development so that individuals and their families can participate effectively in the community. The authors suggest several specific value-based questions and criteria that can be used to evaluate the policy that is being considered. With regard to the family, an example of a criterion suggested is the question, "Does the policy improve the liaison or linkage functions of families as they relate to the social resources and supports they need?" The authors point out that:

> The goal of such policies is to identify family needs, locate the informal and formal resources necessary for meeting those needs, and help link families with identified resources.

Strengthening Families, Nicholas Hobbs, Paul Dokecki, Kathleen

Hoover-Dempsey, Robert Moroney, Mary Shayne, and Karen Weeks, Jossey-Bass Publishers, 1984, page 46.

9525.0035 [See repealer]. It is necessary to repeal this part because the county board case management responsibilities have been moved to part 9525.0012 with revisions. Further, those county board responsibilities that are not specific to mental retardation or related conditions case management will be incorporated into parts 9550.0010 to 9550.0092 (Rule 160), to the extent possible. The move is necessary to accomplish the format change of the rule.

9525.0012 COUNTY BOARD CASE MANAGEMENT RESPONSIBILITIES.

Subpart 1. **Provision of case management.** This subpart modifies the requirements previously found in part 9525.0035, subpart 1. The changes are necessary to clarify when and to whom the county board must provide case management. In order to facilitate informed choice by the person, it is reasonable to require the county to inform the person or their legal representative of available services by providing them with a written description and explanation of services. See part 9525.0004, subpart 14 for further discussion of the need and reasonableness of the informed choice requirement.

It is reasonable to refer to the requirements of part 9550.0010 to 9550.0092 (Rule 160) because Rule 160 governs county administration of community social services. It is reasonable to allow the county board to contract for the provision of case management services to best meet the individual needs of persons in an efficient manner. Further, allowing the county board to contract for these services is consistent with Minnesota Statutes, section 256E.08, subdivision 4, which provides that:

> The county board may contract for community social services programs with a human services board, a multi-county board established by a joint powers agreement, other political subdivisions, or private organizations.

It is reasonable to require that case management begin upon designation of a case manager and continue until services are terminated under subpart 7, to inform those affected by parts 9525.0004 to 9525.0036 of the points at which case management is initiated and terminated.

It is necessary and reasonable to include provision for emergency services because on the basis that from time to time counties

deal with persons who are in need of immediate services in order to protect their health and safety, but who have not yet received a diagnosis under part 9525.0016. It is necessary to define the term "emergency services" because when emergency services are required, case management may be provided notwithstanding a lack of fulfillment of the requirements under this part. The definition given is reasonable because it clearly limits emergency services to those persons who are at imminent risk of harm. It is reasonable to limit the emergency provision of case management to only such life-threatening situations, in order to otherwise facilitate compliance with the requirements that have been established which assure that the need for case management is demonstrated and that appropriate services are then provided.

It is necessary to define the term "person who might be eligible for case management" because in some cases where emergency services are required, the person may not actually have a diagnosis of mental retardation or a related condition at that point in time and may ultimately not qualify for services under parts 9525.0004 to 9525.0036 at all. However, emergency services are still necessary.

Subpart 2. **Designation of case manager.** This subpart modifies the requirements previously found in part 9525.0035, subpart 2. The change is principally a format change. The need and reasonableness for this provision as previously presented by the Department remains applicable.

The additional provision is necessary to clarify the county's responsibility when there is a change in the designation of case manager. During the advisory committee process, some members expressed concern that at times changes are made in case manager designation without promptly notifying those affected. Such situations cause unnecessary confusion and frustration for persons receiving services, their legal representative, family members, and service providers. Accordingly, it is reasonable to require the county board to send a written notification of a change in case manager to the person, the person's legal representative and advocate, if any, and all service providers. This notification assures that these persons are made aware of the change and have current information about who to contact with concerns or questions regarding services. The ten-day timeline for notification is reasonable because it prevents unnecessary confusion and avoids potential problems that could arise if persons were not informed of a change in case manager.

Subpart 3. **Purchase of case management.** This subpart modifies the provision previously found in part 9525.0035, subpart 3. The change is principally a format change. The requirements

previously contained in part 9525.0035, subpart 5 are now divided into subparts 3 and 4 in this part for clarification purposes.

The changes in this subpart are necessary to avoid any conflict of interest that could arise between a case manager's interests as a provider of other services or as an employee of a person who provides other services to the person, and their responsibility as a case manager. This change is reasonable because it clarifies that the case manager must not have a direct or indirect financial interest in the provision of other services for the person.

Subpart 4. **County request to provide case management and other services.** As stated above in subpart 3, this subpart also modifies the requirements previously found in part 9525.0035, subpart 3. The requirements are separated into two distinct provisions in order to clarify those limited circumstances under which the county board may be allowed to provide both case management and other services. It is reasonable to allow a county board to provide services where the separation may cause undue hardship and where safeguards to prevent conflict of interest have been established.

The criteria under this subpart are reasonable because it recognizes that the county may have developed an alternative method of preventing conflict of interest. If it can be shown that any potential conflict of interest has been eliminated through alternative means, then the person's best interests are still being safeguarded.

This subpart is further reasonable because it clearly requires that the actual person providing case management services may not be involved in the provision of other services to the person. Therefore, the county must demonstrate that no other services will be provided to the person by that case manager.

Subpart 5. **Procedures governing minimum standards for case management.** This subpart modifies the standards previously found in part 9525.0035, subpart 5. The changes are necessary to streamline and simplify the rule. The requirement that counties must establish written procedures governing case management is mandated by Minnesota Statutes, section 256B.503(c).

Items A through C are reasonable because counties are afforded flexibility to establish case management procedures which meet their particular county's need while requiring that the procedures are developed consistent with and in a manner which facilitates compliance with parts 9525.0004 to 9525.0036.

The need and reasonableness as previously presented by the Department, for requiring copies of these procedures to be kept on file and made available as described in this subpart, remains applicable.

Subpart 6. **Case manager qualifications and training.** This subpart modifies the qualification requirements previously found in part 9525.0155, subparts 1 and 2. The change is principally a format change. The changes are necessary to eliminate an obsolete rule provision.

The need and reasonableness for items A and B, as previously presented by the Department remain applicable. The provision for a variance from the case manager qualifications, previously allowed under part 9525.0155, subpart 1 is no longer necessary because it provided for an initial grace period during which noncompliant counties were to adjust their personnel policies to meet the requirements of this subpart. Since the case management rule has been in effect since 1987, such a grace period is no longer relevant or necessary.

The changes are further necessary to clarify that the training requirements under this subpart apply to case aides as well as to case managers. During the advisory committee process, a number of members expressed concern that part 9525.0155, subpart 2 was silent with respect to training for case aides and that consequently, in some counties case aides were not receiving training. The changes are reasonable because they clarify the training requirements and prevent future confusion in this regard.

The importance of case manager training has been stressed in much of the literature on case management. For example, Lyle Wray in a chapter entitled *Local Issues in Case Management*, points out that given the growing demands in the field, a more systematic plan of action is needed. He notes that, "Staff must understand what is expected of them and have the skills needed to perform their duties so that they are and feel competent to perform the tasks required of them." *Case Management-Historical, Current and Future Perspectives*, Mary Hubbard Linz, Patricia McAnally & Colleen Wieck, 1989, page 87.

In this chapter, Wray references materials written by Danley and Anthony, in which they discuss guidelines for the development of training programs for case managers, including the following:

(1) training should be tailored to the client outcome goals of an agency,
(2) the goals of a training program should be measurable,

> observable, and capable of being evaluated,
> (3) selection of trainers should depend on clearly specifying the goals of the training and selecting trainers relevant to those goals, and
> (4) the inability to retain good staff is in part a function of their being asked to achieve goals for which they do not have the needed training.

Id., referencing Danley, K., & Anthony, W. *The Development of People Power in CSP Projects: Status, Implications, and Future Directions*, Boston University Rehabilitation and Research Training Center, 1981.

Further, in a 1986-1989 study of case management services funded by the Governor's Planning Council on Developmental Disabilities, it was concluded that one of the most critical areas to address immediately if services are to become more effective is the area of case manager training. During this three-year project, case manager training resources were developed and tested throughout Minnesota. In highlighting the training, the report noted that:

> The training was an ongoing process which included philosophy, values and basic information about case management and service delivery in Minnesota. The training was flexible and individualized. The project evaluation report concluded that it may be possible to improve the current interdisciplinary team approach by co-training parents and county case managers.

Shaping Case Management in Minnesota: in theory, reality and practice, Governor's Planning Council on Developmental Disabilities, January 1991, page 7.

Subpart 7. **Service authorization.** This subpart modifies requirements previously found in part 9525.0035, subpart 6. The changes are necessary to streamline and simplify the rule. The changes are consistent with Minnesota Statutes, section 256B.092, subdivision 1, which requires that the county of financial responsibility shall ". . .authorize services identified in the person's individual service plan."

This subpart is necessary to assert the responsibility to determine the adequacy and quality of services while considering the effectiveness and cost of services. Prudent use of public funds mandate that services be evaluated for effectiveness before committing the use of public funds. It is also necessary to assure that unauthorized services are not funded and that authorization requires that the need for services be established in the person's Individual Service Plan. The Developmental

Disabilities Act states:

> The Federal Government and the States both have an obligation to assure that public funds are not provided to any institutional or other residential programs for persons with developmental disabilities that (A) does not provide treatment, services, and habilitation which is appropriate to the needs of such persons; or (B) does not meet ...minimum standards.

42 U.S.C. §6009 (3).

Subpart 8. **Termination of case management duties.** This subpart modifies requirements previously found in part 9525.0035, subpart 7. The change is principally a format change. The changes are necessary to streamline the rule and to clarify those circumstances under which case management may be terminated.

Item A: Item A is reasonable because it facilitates the person's right to choice regarding services. It is appropriate for the legal representative to make this choice, as necessary. It is reasonable to require a written request to assure there is documentation of the person's choice, particularly in the case of a subsequent case management appeal. A written request also protects the person from misinterpretation by others of inadvertent or impulsive verbal requests for termination of services.

Items B and C: Items B and C are reasonable because officially discontinuing case management after the death of an eligible person or after the person moves from the state updates the county records and facilitates accurate record keeping.

Item D: This criterion is reasonable because case management services authorized under Minnesota Statutes, section 256B.092, are to be provided only to persons with a diagnosis of mental retardation or a related condition.

9525.0045 [See repealer]. The deletion of this part is essentially a format change. The diagnostic provisions have been moved to part 9525.0024 under case management administration, and modified as indicated below. The deletion of this rule part is reasonable to accomplish this format change.

9525.0016 CASE MANAGEMENT ADMINISTRATION.

Subpart 1. **Intake.** This subpart is necessary to implement statute. Minnesota Statutes, section 256B.092, was amended in

the 1991 session to distinguish case management administrative functions from case management services. Section 256B.092, subdivision 1a (a)(1) specifically identifies intake as one of the primary case management administrative functions.

It is reasonable to provide that the intake function shall be conducted according to established county procedures to avoid unnecessary duplication of effort and to provide counties with maximum flexibility. It is reasonable to allow counties the flexibility and professional judgment to determine the type of intake process that best meets the needs of their particular county because intake is considered to be an administrative function and counties as a part of their administrative process have already established procedures to govern intake. The 87 counties vary greatly in terms of intake responsibility. For example, Hennepin County will have a significantly greater intake responsibility than Koochiching County. Further, it is reasonable to require that the intake procedures meet the requirements under part 9550.0070 because Rule 160 governs community social services administration functions and already contains requirements specific to the counties' intake responsibilities. Referencing Rule 160 assures consistency between Department rule requirements and avoids unnecessary duplication.

Subpart 2. **Diagnostic definitions.** This subpart contains the definitions of those terms that are relevant to the diagnostic requirements under subparts 1, 3, and 4.

It is necessary to define the terms, "deficits in adaptive behavior", "significantly subaverage intellectual functioning", and "substantial functional limitations" because they have a meaning integral to the understanding of the diagnostic requirements under this subpart.

Item A: The definition of "deficits in adaptive behavior" is necessary because by definition, the diagnosis of mental retardation requires the presence of severe deficits in adaptive behavior existing concurrently with significantly subaverage intellectual functioning. The definition given is reasonable because it is sufficiently specific to provide a standard for determining whether a behavior is adaptive and thus for determining whether an individual program plan has the required focus. The definition is also consistent with the definition used in other department rules governing the provision of services to persons with mental retardation or related conditions.

Item B: The definition of "significantly subaverage intellectual functioning" is necessary to define a specific component integral to the diagnosis of mental retardation. Part 9525.0004, subpart 20, defines "person with mental retardation." The definition found in subpart 20 refers to the diagnosis conducted under this subpart, which requires that the person must have significantly subaverage intellectual functioning, in conjunction with other criteria. Therefore, the meaning of this term is central to the understanding of the diagnosis of mental retardation.

The definition given is reasonable because it is consistent with the current federal and state-of-the-art standards used in the diagnosis of mental retardation. As stated above in subpart 33, the 1992 revised manual of the American Association on Mental Retardation, includes significantly subaverage intellectual functioning as a component in its definition of mental retardation.

Similarly, William Frankenberger and Kathryn Fronzaglio in the article, "States Definitions and Procedures for Identifying Children with Mental Retardation: Comparison Over Nine Years," provide results of a nine year study which substantiates that "the trend is toward establishing an IQ cutoff of 70, but allowing multidisciplinary teams to consider the standard error of measurement when making placement decisions." *Mental Retardation, Vol. 29*, No. 6, at 320.

In the AAMR's revised manual's discussion of the intellectual component of mental retardation, it provides the following information:

> Mental retardation is characterized by significantly subaverage intellectual capabilities or "low intelligence." If a valid IQ score is not possible, significantly subaverage intellectual capabilities means a level of performance that is less than that observed in the vast majority (approximately 97 percent) of persons of comparable background.

Mental Retardation: Definition, Classification and Systems of Supports, 9th Edition, 1992, page 14.

Item C: It is necessary to define the term "substantial functional limitations" because it is another component which is integral to the diagnosis of mental retardation. The definition of "person with mental retardation" also requires that the person have substantial limitations in present functioning, in conjunction with other criteria. Therefore, the meaning of this term is central to the understanding of the diagnosis of mental

retardation.

The definition given is reasonable because it is consistent with the current federal and state-of-the-art standards used by professionals in the diagnosis of mental retardation. As stated above, the revised manual of the American Association on Mental Retardation includes substantial limitations in present functioning as a component in its definition of mental retardation. The AAMR defines substantial limitation in functioning as a "fundamental difficulty in learning and performing certain daily life skills."

In the manual's discussion of the substantial functional limitations component of mental retardation, the AAMR provides the following insight:

> Mental retardation is present when specific intellectual limitations affect the person's ability to cope with the ordinary challenges of everyday living in the community. If the intellectual disabilities have no real affect on functioning, then the person does not have mental retardation.

Id. at 13.

The manual goes on to say that:

> The intellectual and adaptive skill limitations in mental retardation may affect functioning in a variety of ways. The relativity of significance means that there is no one way that defines "retarded" performance. Every person with mental retardation will differ in the nature, extent and severity of their functional limitations, depending on the demands and constraints of their environment and the presence or absence of supports. The current definition reflects this fact by requiring the presence of limitations in two or more of a variety of adaptive skill areas, but does not require any one single limitation or any specific combination of limitations.

Id.

The definition given is reasonable because it is consistent with the above-mentioned federal standards.

Subpart 3. **Diagnostic requirements to determine eligibility for case management.** This subpart modifies the requirements previously found in part 9525.0045. The changes are necessary to accomplish the format change and to update diagnostic standards

to be consistent with federal, state-of-the art standards in the field of mental retardation and related conditions. This subpart is also necessary to implement statute. As stated above in subpart 1, Minnesota Statutes, section 256B.092, was amended in the 1991 session to distinguish case management administrative functions from case management services. Section 256B.092, subdivision 1a (a)(2) specifically identifies diagnosis as one of the six primary case management administrative functions. Minnesota Statutes, section 256B.092, subdivision 1 requires a diagnosis of mental retardation or a related condition as a condition of eligibility for case management.

It is necessary and reasonable to specify the component of the comprehensive diagnostic evaluation in order to facilitate a complete and accurate diagnostic evaluation consistent with accepted professional standards.

It is necessary and reasonable to provide for eligibility for case management for a child under the age of five who demonstrates significantly subaverage intellectual functioning concurrently with demonstrated deficits in adaptive behavior, but for whom a diagnosis may be inconclusive because it is not always possible to be assured of the diagnosis at such an early age. This provision is further reasonable because it is consistent with the policy of avoiding placing labels on persons, particularly children.

Item A: It is necessary to require a standardized test that measures the person's intellectual functioning because intellectual functioning is one of the primary components of the definition of mental retardation. The AAMR defines mental retardation as:

> Mental retardation refers to substantial limitations in present functioning. It is characterized by <u>significantly subaverage intellectual functioning</u>, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18.

Mental Retardation: Definition, Classification and Systems of Supports, 9th Edition, 1992, page 5 (emphasis added).

The AAMR defines subaverage intellectual functioning as "an IQ standard score of approximately 70 to 75 or below, based on assessment that included one or more individually administered general tests developed for the purpose of assessing intellectual

functioning." *Id.*

There are a number of standardized tests of intellectual functioning which are commonly administered for measuring a person's intellectual functioning. The instruments most commonly used for the assessment of intellectual functioning are the *Stanford-Binet Intelligence Scale* (Thorndike, Hagen, & Sattler, 1986); one of the Wechsler scales, including the *Weschler Adult Intelligence Scale* (WAIS-Wechsler 1981) and the *Weschler Intelligence Scale for Children* (WISC-R, Wechsler, 1974); and the *Kaufman Assessment Battery for Children* (Kaufman and Kaufman, 1983).

Validity of the IQ score is very important to the use of the score for diagnostic purposes. Therefore, it is reasonable to require that the test which is administered be normed for persons of similar chronological age. The AAMR further illustrates the importance of test validity in its following remarks:

> General issues in the assessment of intellectual functioning and adaptive skills derive in large part from those issues that related to measurement in any other dimension. Therefore, general concerns for validity, reliability, and more specifically, for stability of measures, generalization, and prediction, as well as appropriateness are critical in assessment of mental retardation.

Mental Retardation: Definition, Classification and Systems of Supports, 9th Edition, 1992, at 43.

It is important to note that the results of intelligence tests provide only one part of an overall assessment. As the definition of "mental retardation" under part 9525.0004, subpart 33 indicates, the significantly subaverage intellectual functioning must exist concurrently with severe deficits in adaptive behavior. In this regard, the AAMR notes that:

> The individual's intellectual functioning in everyday settings and roles must be consistent with the performance on the standardized measures. Test scores, without confirmation from individual's functioning in the context of age, setting, and environment, can never be accepted as sufficient for the diagnosis of significant subaverage intellectual functioning.

Id. at 36.

It is necessary to require that the diagnosis also include an assessment of adaptive behavior because disabilities in adaptive

skill areas is the other major component of the definition of mental retardation and related conditions. (See AAMR definition of mental retardation stated in item A). The relationship and distinction between the intellectual functioning and adaptive skills components of the definition of mental retardation are highlighted by the Minnesota University Affiliated Program on Developmental Disabilities in its following discussion:

> First, the two constructs differ in the degree of emphasis placed on everyday behavior and abstract thought processes. Adaptive behavior is usually defined to reflect everyday behavior, while intelligence is more reflective of abstract thinking and academic processes. Second, intellectual assessment. . .emphasizes the maximal performance of the individual, while adaptive behavior is concerned with common or typical functioning. Third, social-emotional or maladaptive behavior domains excluded from most conceptions of intelligence, are frequently considered to be integral aspects of adaptive functioning, particularly as reflected by operationalized assessment procedures.

Exploring the Structure of Adaptive Behavior, Minnesota-University Affiliated Program on Developmental Disabilities, 1987, pages 8-9.

There are a number of standardized assessments of adaptive behavior available, including the *Vineland Adaptive Behavior Scale*; the *Adaptive Behavior Inventory*; the *AAMD Behavior Scale for Adults* and the *AAMD Behavior Scale for Children*; the *Normative Adaptive Behavior Checklist*; and the *Scales of Independent Behavior*.

It is necessary and reasonable to provide for the use of assessments of developmental functioning for children because instruments designed for adults are not necessarily appropriate for determining the specific, unique needs of a young child. There are a number of standardized assessment instruments developed specifically for use with children, such as the following commonly used instruments primarily developed for the assessment of children under the age of five: 1) *Battelle Developmental Inventory (BDI)*, DLM Teaching Resources, 1984; 2) *Bayley Scales of Infant Development*, Psychological Corporation, 1969; 3) *California Preschool Social Competency Scale*, Consulting Psychologist Press, Inc., 1969; 4) *Carolina Developmental Profile*, Kaplan School Supply Corp., 1975; 5) *Denver Developmental Screening Test (DDST)*, William K. Frankenberg & Josiah B. Dodds, 1973; and 6) *Diagnostic Inventory of Early Development (Brigance)*, Curriculum Associates, 1978. (See, *Instruments and Procedures for Assessing Young Children*, Ann

Bettenburg, Minnesota Department of Education, 1985).

For example, the *Bayley Scales of Infant Development* were developed specifically to assess the cognitive/developmental skills of children from two months to two and a half years. The significance is using standardized tests developed for children is illustrated by the following remarks of the University of Minnesota Institute on Community Integration:

> When selecting an instrument, the examiner should determine whether the author considered the following factors: age, sex, acculturation of parents, geographic factors, race, date of the norms, special population characteristics (i.e., inclusion of children with specific linguistic problems if the purposes of the test is to identify such children.

Assessing Children with Low Incidence Handicaps-A Resource Guide, Institute on Community Integration-university of Minnesota, 1991, page 7.

Similarly, the authors of *Best Practices for Assessing Young Children*, stress that:

> Infants and young children differ from school-aged children in many important ways, and these differences have a significant impact on assessment strategies. For example, because infants and young children do not yet have fully developed language skills, assessment cannot center on a question-and-answer format as it does with school-aged children. Nor have young children learned the school-related behaviors of complying with adult requests and sitting still for long periods of time.

Elizabeth Bull Danielson, P.H.D; Evelyn Lynch, E.D.D.; Anne Monyano, M.S.; Bonnie Johnson, P.H.D., and Ann Bettenburg, M.S., Minnesota Department of Education, 1988, page 4.

Further, the Department of Health and Human Services in its 1991 revision of the regulations governing disability for children for purposes of Supplemental Security Income, noted that there were a number of commenters that expressed concern about the need to address the problem assessing disability in infants. Such concern was based on the fact that infants are often difficult to evaluate because they exhibit a narrow range of medical findings and can not be tested or be precisely diagnosed. In consideration of these comments, the Health and Human Services, Social Security Administration 1991 rules on equivalence and publication of Listing 112.12 of the childhood mental listings

contains a listing specifically for infants from birth to age 12 months. This provides a means by which infants may establish both that they have medically determinable impairments and that they are disabled on their functional impairment.

Item B: It is reasonable to require a social history in addition to a test of intellectual functioning and an assessment of adaptive skill areas in order to get a well-rounded, accurate assessment of the person's functioning level and corresponding needs. The identification and assessment of social and environmental factors which may have contributed to the person's current level of functioning is reasonable because it is consistent with the current national philosophy on the diagnosis of mental retardation. Social histories provide critical information regarding the chronological and developmental history of the person. It is reasonable to require a social history because it provides information that may be directly relevant to the person's diagnosis and need for services and supports. For example, a social history provides information regarding the person's developmental history as well as specific facts about the chronological age at which the mental retardation or related condition was manifested. This information is essential to the diagnosis of mental retardation, which by definition requires that the condition be manifested prior to the age of 22 years.

The AAMR defines environment as "the specific settings in which the person lives, learns, plays, works, socializes, and interacts." *Mental Retardation: Definition, Classification and Systems of Supports*, 9th Edition, 1992, page 12.

As the AAMR indicates in its manual, a description of these environments are necessary for a full understanding of the concept of mental retardation. In fact, the current AAMR definition of mental retardation identifies the key elements of mental retardation as capabilities, environments, and functioning. The current AAMR definition of mental retardation differs from previous definitions in that it also recognizes the impact of environment on a person's functioning. According to the AAMR:

> Compared to the definitions in previous AAMR manuals, the present definition specifies adaptive skill areas (and delineates how these skills should be documented), emphasizes the relation among limitations in intellectual and adaptive skills, environmental influences on the impact of these limitations, and the intensities of supports needed to improve functioning in the community.

Id. at 9.

The significance of environment to the diagnosis and provision of services to persons with mental retardation is illustrated in the following comments by the AAMR:

> Positive environments foster the growth, development and well-being of the individual and enhance the individual's quality of life. For individuals with mental retardation, these positive environments constitute settings that are typical of their age peers and that are appropriate for the individual's sociocultural background. It is within such settings that the individual with mental retardation is most likely to achieve optimal interdependence and productivity and to enjoy maximal inclusion in the life of the community.

Mental Retardation: Definition, Classification and Systems of Support, 9th Edition, 1992, page 12.

In essence, the AAMR definition emphasizes that functioning can be influenced as much by the nature of the person's environment as it is by the person's capabilities.

It is necessary to require information regarding the age at which mental retardation or a related condition was manifested to assure consistency with the current statute as well as federal definitions of "mental retardation" and "related conditions." Both the definitions of "person with mental retardation" under part 9525.0004, subpart 20, and the definition of "person with a related condition" under part 9525.0004, subpart 21, require that the condition is manifested before the person reaches 22 years of age.

Further, the current AAMR definition of "mental retardation" emphasizes the developmental period as the time in which mental retardation is initially manifested. Although the age of onset under the AAMR standards is set at age 18, the significance of age of onset to the diagnosis of mental retardation or a related condition is a major component in the diagnosis as illustrated in the following remarks by the AAMR:

> . . .an individual with socially typical functioning who sustains an injury after the developmental period, and whose subsequent functioning is deficient in both cognitive and adaptive capabilities, is not considered to have mental retardation. On the other hand, an individual who develops typically and then sustains a developmental regression for any reason prior to age 18 years is considered to have mental retardation.

Mental Retardation: Definition, Classification and Systems of Supports, 9th Edition, 1992, page 16.

Therefore, mental retardation is manifested during the developmental period, as distinguished from conditions arising after adulthood has been achieved.

Item C. It is necessary to require a medical evaluation of the person as a part of the diagnosis because health and physical considerations are an essential component of the diagnosis. It is further necessary to require a medical history as part of the diagnostic assessment to assure complete consideration of etiological factors as well as health and medical concerns. Preparation of historical information is reasonable because in some case, the person's disability may be directly or at least partially attributable to medical factors. Further, thorough and accurate information about the person's medical needs is essential to determining service and supports and to the individual planning process.

Mental retardation is often associated with other disabling conditions. Further, the state of health of the individuals is often affected. In general, the more severe the mental retardation, the greater the likelihood of other types of disabling conditions. See *Mental Retardation: Definition, Classification and Systems of Supports*, American Association on Mental Retardation, 9th Edition, 1992, pages 61-68.

A careful medical history and a physical examination is essential in assessing persons with mental retardation and delineating their health status and concomitant health problems. The importance of the requirements in item C is demonstrated by the AAMR in its following statements:

> For people with mental retardation, the effects of health or functioning also influence assessment, environmental factors, and the need for supports and services.

Id. at 61.

> People with mental retardation have health problems that require special attention because of their complexity. For some individuals, the underlying disorder that is the etiology of the mental retardation may also predispose the individual to other health problems.... The complexity of the health service needs of individuals with these health problems requires a coordination and often multidisciplinary approach by a team of health professionals.

Id. at 64.

It is reasonable to require that the medical history be prepared by a licensed physician to facilitate thorough and accurate assessment of the person's history and needs.

It is reasonable to allow the use of diagnostic information obtained by other providers because this is specifically provided for under statute. Minnesota Statutes, section 256B.092, subdivision 1, provides that: "Diagnostic information, obtained by other providers or agencies, may be used to meet the diagnosis requirements of this section." This is also reasonable because it avoids unnecessary duplication of effort and subjecting the person to unnecessary assessment procedures.

Subpart 4. **Administration of tests of intellectual functioning and assessments of adaptive behavior.** This subpart is necessary to establish professional standards for the administration of tests of intellectual functioning and assessments of adaptive behavior and developmental functioning. It is reasonable to require that such tests be administered by a licensed psychologist, a certified school psychologist, or a certified psychometrist because psychological testing is within a psychologist's scope of practice based on their graduate school preparation and supervision. Testing is a specialty area of practice. It is a commonly-accepted standard in the field of mental retardation that tests of intellectual functioning are to be administered by individuals who are qualified and experienced in the administration of these instruments and who meet state credentialing regulations for test administration. See, e.g., *Mental Retardation: Definition, Classification and Systems of Supports*, 9th Edition, 1992.

It is reasonable to require that the tests of intellectual functioning be administered by a professional trained and experienced in administration of these tests in order to facilitate proper and consistent test administration. This requirement is further reasonable because it is consistent with medical assistance standards under which only licensed psychologists or licensed consulting psychologists are reimbursed for test administration. The medical assistance payment limitations for psychological testing are explained in the Department's Medical Assistance Provider Manual, which specifically provides that:

> The psychological testing must be conducted by a psychologist with competence in the area of psychological testing as stated to the Board of Psychology. The administration and scoring of the psychological tests may be

> carries out under the clinical supervision of a licensed psychologist, by a psychometrist or psychological assistant or as part of a computer-assisted psychological testing program. The face-to-face interview and interpretation of test results must be conducted by the licensed psychologist or licensed consulting psychologist.

Section 5205.09.

Requiring that these instruments be administered by properly credentialed professionals protects the best interests of the person by facilitating an accurate diagnosis and safeguarding against inappropriate diagnosis, placement, and planning for the person.

With regard to the assessment of adaptive behavior skills, there are a variety of adaptive behavior scales. There are a variety of tools which are commonly used as standard measures of adaptive behavior, including the *Vineland Maturity Scale* (Doll, 1953); the *AAMD Adaptive Behavior Scales* (Nihira, Foster, Shellhaas, & Leland, 1974); the revised *Vineland Adaptive Behavior Scales* (Sparrow, Bala, Cichetti, 1984); the *Scales of Independent Behavior* (Bruininks, Woodcock, Weatherman, & Hill, 1984); and the *Comprehensive Test of Adaptive Behavior* (Adams, 1984). The scales differ in their quality, standardization sample, and intended usage. Some focus specifically on individuals with severe disabilities and others mild disabilities. With regard to which instrument should be used, the AAMR notes that "specific adaptive skill concerns, for example, in the domains of communication and social skills, are more appropriately assessed with instruments designed for those respective, specific domains rather than through reliance on general adaptive behavior skills." *Id.* at 41.

The AAMR points out that in addition to selecting instruments that are technically correct, the professional must also be cautious to select ones designed for the particular population, the functional purpose, and the specific adaptive skills intended. Further, the AAMR recommends the use of adaptive skill assessments that are normed within community environments on individuals who are of the same age grouping as the individual being evaluated.

It is necessary to require that assessment procedures be adjusted to accommodate sensory, health or motor deficits to facilitate test validity and to avoid bias of the test results. For example, the assessment of a person with a hearing impairment may require a nonverbal assessment instrument, while the assessment of a person with a visual impairment precludes using instruments

which include cards, pictures, or object manipulation. According to the AAMR, because using traditional testing procedures in such cases could result in discriminatory assessment:

> It is, therefore, paramount that persons charged with assessing both intellectual functioning and adaptive skills take special measures to ensure a fair and accurate evaluation. Evaluators must be able to distinguish limitations in intellectual or adaptive areas from problems associated with sensory or physical difficulties. Such persons must be prepared in the use of specialized instruments and/or modifications in existing measures. The results of intelligence testing in particular should be interpreted cautiously.

Mental Retardation: Definition, Classification and Systems of Supports, 9th Edition, 1992, page 47.

In order to facilitate a valid test score, it is also necessary to require that assessment procedures be modified to accommodate background, cultural or language differences. This concern was specifically addressed in the Education for All Handicapped Children Act (1975), which specifically required that all states establish:

> [P]rocedures to assure that testing and evaluation materials and procedures utilized for the purposes of evaluation and placement of handicapped children will be selected and administered so as not to be racially or culturally discriminatory. Such material or procedures shall be provided and administered in the child's native language or mode of communication, unless it is clearly not feasible to do so, and no single procedure shall be the sole criterion for determining an appropriate educational program for a child.

42 U.S.C. §612 (5)(c).

According to the AAMR, when an individual's "background reflects cultural or linguistic variances, alternate approaches should be considered. *Mental Retardation: Definition, Classification and Systems of Support*, 9th Edition, 1992, page 46. In this regard, the AAMR states further that:

> The central concerns are that sociocultural background as well as the individual's primary language must be considered in the selection and administration of assessment instruments and the interpretation of the results obtained from those assessment activities.

Id.

Subpart 5. **Diagnostic conclusions and recommendations.** This subpart is necessary to place emphasis on the requirement that the final diagnosis and recommendations are to be based on all three types of assessment data defined in subpart 3, items A through C and that this data is to be carefully considered collectively. This requirement is reasonable because it is consistent with professional practice standards commonly accepted in the field of developmental disabilities. The Code of Federal Regulations, Title 20, part 404, section 12.00(d), states:

> Narrative reports of intellectual assessment should include a discussion or whether or not obtained I.Q. scores are considered valid and consistent with the individual's developmental history and degree of functional restriction.

This subpart clarifies that reliance on solely one assessment source is an insufficient basis for diagnostic conclusions.

The requirement that substantial limitation in current functioning, significantly subaverage intellectual functioning and disabilities in adaptive skills must not be the result of mental illness or an emotional disturbance is reasonable because it is consistent with statute. Minnesota Statutes, section 252.27, subdivision 1a, defines a "related condition" as:

> [A] severe, chronic disability that meets all of the following conditions: (a) is attributable to cerebral palsy, epilepsy, autism, Prader-Willi syndrome, or any other condition, other than mental illness as defined under section 245.462, subdivision 20, or an emotional disturbance, as defined under section 245.4871, subdivision, found to be closely related to mental retardation because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with mental retardation and requires treatment or services similar to those required for persons with mental retardation;....

(*emphasis added*).

Further, mental illness is excluded from the federal definition of "related condition." Some commenters opposed the proposed federal regulations on the basis that they will exclude persons with mental illness from the definition of "persons with related conditions" and that this will result in the elimination if Medicaid coverage for children and adolescents who are emotionally disturbed or have other psychiatric conditions. Some

rule advisory committee members have expressed similar concerns with Minnesota's definition and rule standards. In this regard, the Department of Health and Human Services responded that:

> We agree that emotionally disabled persons can benefit from individually developed care plans but do not support the contention that emotionally disturbed individuals, who may have average or above average intelligence, generally should be placed in facilities which are designed for mentally retarded persons.

51 *Federal Register* 19179 (May 28, 1988).

It is reasonable to require that when standardized tests of intellectual functioning or assessments or adaptive skills are not available due to age or can not be administered due to severe illness, that the diagnosis may be based on available information or be reconstructed from available information from persons knowledgeable about the person's developmental history. This allows for some flexibility under those limited circumstances where administering a test or assessment instrument is not feasible. Provision for such flexibility is reasonable because it is in the best interest of the person to determine their individual needs and to plan for services where indicated.

Subpart 6. **Review of diagnosis of mental retardation or a related condition.** This subpart modifies the review requirements previously found in part 9525.0045, subparts 2 and 3. The change is principally a format change. The change is necessary to streamline and clarify the case manager's responsibility to review the person's diagnosis. This subpart is necessary to determine if the person receiving services is still functioning as a person with mental retardation or a related condition, and therefore still entitled to case management. It is also necessary to determine whether the person is receiving services that are appropriate for their condition. The requirement previously under part 9525.0045 for a review of the diagnosis every three years continues to be reasonable on the basis previously presented by the Department. However, the changes are necessary to clarify areas of confusion and misinterpretation. In the course of conducting public informational meetings regarding diagnostic standards for mental retardation or related conditions, a number of case managers expressed confusion regarding the review requirements and, in some cases, were misinterpreting the rule to require a completely new diagnostic process every three years. The changes are reasonable because they clarify that the diagnosis need only be reviewed by the case manager at least every three years, and that only when determined necessary should a new diagnostic process be sought. This could

include when recommended by the interdisciplinary team, or when the diagnosis is challenged by the person, guardian or a significant service provider.

Subpart 7. **Screening.** This subpart modifies the screening team requirements previously found at part 9525.0065, subpart 1. The change is principally a format change. The changes are necessary to implement statutory amendments. Minnesota Statutes, section 256B.092, subdivision 7 requires counties to establish screening teams to evaluate the need for the level of care provided by residential-based habilitation services, residential services, training and habilitation services, and nursing facility services. Further, subdivision 7 requires that:

> The evaluation shall address whether home and community-based services are appropriate for persons who are risk of placement in an intermediate care facility for persons with mental retardation or related conditions, or for whom there is a reasonable indication that they might require this level of care.

It is necessary and reasonable to require that in cases where the person has an overriding health care need that the county comply with Minnesota Statutes, section 256B.092, subdivision 7, to facilitate compliance with the statutory requirements that address such needs. It is reasonable to reference statute rather than to repeat the requirement because in the event that this requirement changes the rule will still be current. Such referencing also avoids unnecessary duplication of language.

It is necessary and reasonable to specifically address cases where the person is under public guardianship because it implements the provision of subdivision 7 which allows the county agency to contract for the public guardianship representation required for the screening or individual service planning process.

Item A: Item A is reasonable because it is consistent with the requirements of Minnesota Statutes, section 256B.092, subdivision 7.

Item B: Item B is reasonable to provide for the participation of all members of the screening team as identified under Minnesota Statutes, section 256B.092, subdivision 7. The invitation of other individuals to the screening is also provided for under subdivision 7.

Subpart 8. **Screening team duties.** This subpart modifies the requirements previously contained in part 9525.0065, subparts 2

and 3. The change is principally a format change. It is necessary and reasonable to move this subpart because the rule has been reformatted. The modifications are necessary to assure consistency with Minnesota Statutes, section 256B.092, subdivision 8. The changes are reasonable because they clarify and streamline the screening team requirements. The need and reasonableness for items A, B, and C as previously presented by the Department remains applicable.

Subpart 9. **Screening document**. This subpart is necessary to implement the requirement of Minnesota Statutes, section 256B.092, subdivision 8(b), which provides that the screening team shall "review health, social, and developmental assessment data using a uniform screening tool specified by the commissioner."

This subpart is further necessary to clarify screening document requirements. This provision is reasonable because it delineates those areas which must be recorded on the screening document. Historically, there has been some confusion and inconsistency on the part of counties, which has lead to noncompliance with specific screening document requirements. For example, in its 1987 federal audit of Minnesota's waiver plan, the Health Care Financing Administration (HCFA) found that some screenings were not performed timely or documented properly. Specifically, the auditor pointed to a case where a person was screened and found eligible, but the screening form was never submitted for the signature of the Department of Human Services regional service specialist. The auditor found that this particular screening was triggered by the finding of the survey and certification team that the client had been inappropriately placed in an ICF/MR, indicating that some screening teams may use different level of care criteria for waivered services than for institutional care. Based on these findings, HCFA recommended that:

> The State should remind case workers, especially in smaller counties where there is no specialization, what the screening requirements are and how they should be documented. The regional service representative should from time to time spot-check such counties to see that the requirements are understood and give technical assistance where needed.

HCFA review of Minnesota Medicaid Program, 1987, page 3.

The requirements in this subpart are reasonable because they are consistent with requirements which must be complied with in order to assure continued federal financial participation. These requirements are consistent Code of Federal Regulations, title

42, section 431.51, which specifically requires free choice of medical assistance providers.

Subpart 10. **Use of screening team recommendations in commitment proceedings.** This subpart modifies the requirements previously found in part 9525.0065, subpart 6. The change is principally a format change. The changes are necessary to implement Minnesota Statutes, section 256B.092, subdivision 8(i), which requires that the screening team shall "(i) make recommendations to a court as may be needed to assist the court in making decisions regarding commitment of persons with mental retardation." It is reasonable to update rule provisions as changes occur in the authorizing statute.

Subpart 11. **Criteria for service authorization.** This subpart modifies requirements previously found in part 9525.0035, subpart 6. The changes are necessary to implement statute and to clarify and streamline service authorization requirements. Minnesota Statutes, section 256B.092, subdivision 1a(a)(4), specifically identifies service authorization as one of the primary case management administrative functions.

Item A: This requirement is reasonable because it is consistent with the authorizing statute. Minnesota Statutes, section 256B.092, subdivision 1, provides requires that:

> [T]he county of financial responsibility shall conduct or arrange for a needs assessment, develop of arrange for an individual service plan, provide or arrange for case management administration and authorize services identified in the person's individual service plan developed according to subdivision 1b.

(*emphasis added*).

Subdivision 1b requires that the individual service plan must identify the person's preferences for services.

Item B: Item B is reasonable because counties already have established procedures by which they authorize services. Therefore, it is unnecessary to establish specific procedural requirements in rule. Further, because counties vary markedly in service authorization needs, particularly from metro to rural counties, this provision affords counties the flexibility to follow those procedures which have been developed to meet their unique administrative needs.

Item C: Item C is reasonable because it acknowledges the existence of contracts and provider agreements as legally binding

instruments which must be duly considered and complied with the process of authorizing services. This provision further facilitates consistency with the contract requirements under parts 9550.0010 to 9550.0092 (Rule 160).

Item D: Item D is reasonable because authorizing the delivery of services by a provider that is able to fulfill the requirements in subitems 1 through 4, is an essential component in assuring the provision of appropriate and adequate services that meet the person's individual needs. Notwithstanding the fact that the standards contained in items A through D have been met, a provider meeting the standards of item E is necessary to assure the actual delivery of services.

Item E: This item is necessary and reasonable to facilitate compliance with applicable regulations governing the authorization of services to persons with mental retardation or related conditions. There are a multitude of state and federal regulations related to authorization of such services as ICF/MR, nursing facilities, medical assistance waivers, state support, and grants. Therefore, it is reasonable to reiterate the responsibility of those governed by this rule to comply with such regulations.

Subpart 12. **Authorization of medical assistance for ICF/MR, home and community-based services, and nursing facility services.** This subpart modifies the requirements previously found in part 9525.0065, subpart 5. The change is principally a format change.

The addition of nursing facility services to this subpart is necessary because the Social Security Act prohibits a medicaid-certified facility, after January 1, 1989, from admitting any person with mental retardation or a related condition:

> ...unless that State mental retardation or developmental disability authority has determined prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility, and, if the individual requires such level of services, whether the individual requires active treatment for mental retardation.

U.S.C. §1919(b)(3)(F)(ii).

In order to comply with this federal requirement and accomplish the requirement for pre-admission screening and annual resident reviews, the Department uses the already established screening process, and an additional assessment to be completed and

reviewed by the state Mental Retardation authority prior to authorizing admission to a facility or the use of medical assistance to fund services.

Item A: Item A is necessary and reasonable because the criteria are consistent with the requirements of parts 9525.0004 to 9525.0036 as well as Minnesota Statutes, section 256B.092, that services must be authorized only for persons with mental retardation or a related condition.

With respect to home and community-based waivered services, Code of Federal Regulations, title 42, section 441.301(b) provides that if the agency furnishes home and community-based services under a waiver, the waiver request must:

> (1) Provide that the services are furnished-
> (i)Under a written plan of care subject to approval by the Medicaid agency;
> (ii)Only to recipients who are not inpatients of a hospital, SNF, ICF, or ICF/MR, and who the agency determines would require the level of care provided in an SNF or ICF (of ICF/MR if applicable) under Medicaid...if not furnished these services.

Further, Code of Federal Regulations, title 42, section 441.302(d) provides that Health Care Financing Administration (HCFA) will not grant a waiver and may terminate a waiver unless the Medicaid agency provides:

> (d) Assurance that when a recipient is determined to be likely to require the level of care provided in an NF or or ICF/MR, the recipient or his or her legal representative will be-
> (1) Informed of any feasible alternative available under the waiver; and
> (2) Given the choice of either institutional or home and community-based services.

Minnesota's federally-approved waiver plan guarantees the federal government that Minnesota will use the same screening document for waivered services as is used for ICF screenings.

With regard to nursing facility services, as stated above, 42 U.S.C. §1919(b)(3)(F) requires preadmission screening to determine that, because of the physical and mental condition of the person, that the person requires the level of services provided by a nursing facility. Further, Minnesota Statutes, section 256B.0911, subdivision 7 provides that:

> ...the local county mental health authority of the local mental retardation authority under Public Law Numbers 100-203 and 101-508 may prohibit admission to a nursing facility, if the individual does not meet the nursing facility level of care criteria or does not need active treatment as defined in Pubic Law Numbers 100-203 and 101-508.

Item B: Item B is reasonable because it is consistent with Minnesota Statutes, section 256B.092, which requires screening teams to evaluate the need for the level of care. It is also consistent with the Code of Federal Regulations, Title 42, section 435.1009 that defines ICF's/MR as institutions for persons with mental retardation and related conditions" who are in need of a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health and rehabilitative services to help each individual function at his highest ability..." The ICF/MR interpretative guidelines go on to say that persons not needing "active treatment services or ICF/MR level of care. . .are not appropriately placed. . .If the State acknowledges that a person does not need active treatment or is inappropriately placed, the Medicaid Agency cannot claim payment for the cost of care of the individuals."

Item C: This requirement is reasonable because it implements Minnesota Statutes, section 256B.092, subdivision 9, which requires that the screening team provide documentation that the most cost-effective alternatives available were offered to the individual or the individual's guardian or conservator. This requirement is further reasonable because it promotes the efficient expenditure of public funds for services.

Item D: Item D is reasonable because it is consistent with the federal requirement under Code of Federal Regulations, title 42, section 441.303 that the person must be given an informed choice among services. The need and reasonableness of this requirement is discussed further at part 9525.0004, subpart 14 in this statement of need and reasonableness.

Subpart 13. **Review of eligibility.** This subpart is necessary to implement statute. Minnesota Statutes, section 256B.092, subdivision 1a (a)(5) specifically identifies review of eligibility for services as one of the primary case management administrative functions. It is reasonable to require an annual review of eligibility for services in recognition that a person's service needs may change. Based on such changes, new or additional services may be indicated. This provision facilitates the provision of appropriate services based on a review of the

person's eligibility and also promotes the prudent use of public funds.

It is necessary and reasonable to require the case manager to place documentation of this review in the person's file in order to facilitate the continued provision of appropriate services that meet the person's individual needs and to demonstrate evidence of compliance with this subpart.

It is reasonable to allow the screening form to serve as documentation of the review and to be incorporated into the individual service plan in order to avoid unnecessary duplication of effort.

Subpart 14. **Conciliation and appeals.** This subpart is necessary to implement statute. Minnesota Statutes, section 256B.092, subdivision 1a (a)(6) specifically identifies responding to requests for conciliation conferences and appeals according to section 256.045, as a case management administrative responsibility of the county. It is reasonable to reference the statute which governs case management conciliation conferences and appeals in order to facilitate compliance. Further, in order to assure that due process is afforded to those involved in a conciliation conference or appeal, it is reasonable to establish in rule specific timelines for conducting the conciliation conference and for submission of the conference report.

It is reasonable to simply cross-reference Minnesota Statutes, section 256.045 regarding conducting the case management appeal because this provision is very specific and it in unnecessary to restate this level of detail in the rule.

9525.0055 [See repealer]. The deletion of this part is essentially a format change. The standards for assessment of individual needs have been moved to part 9525.0024, subparts 1, 2, and 3 under case management service practice standards and modified as indicated below. The deletion of this rule part is reasonable to accomplish this format change.

9525.0024 CASE MANAGEMENT SERVICE PRACTICE STANDARDS.

Subpart 1. **Assessment of individual needs.** This subpart modifies the standards previously found in part 9525.0055, subpart 1. This subpart is necessary to implement Minnesota Statutes, section 256B.092, subdivision 1, which requires that "the county of financial responsibility shall conduct or arrange for a needs assessment." The changes are necessary to assure

consistency with statute.

Requiring assessment of the persons functional skills and needs, as well as supports and services available to meet the person's needs is necessary in order to develop an individualized service plan that identifies the extent and nature of the person's needs, the capacity of the person to meet their own needs, sources of informal supports, services, benefits or opportunities that are available or can be developed to meet the person's needs as well as identifying individualized goals for the person. It is reasonable because it is consistent with the standard commonly accepted in the field of developmental disabilities. According to the ACDD:

> Individualized assessment is the initial step in the development of an effective plan.... The assessment process should be designed to develop a picture of the functional skills and needs of the individual.

Standards and Interpretation Guidelines for Services for People with Developmental Disabilities, 1990, page 129.

Similarly, the AAMR's 1992 manual states that:

> The initial purpose of assessment is to ascertain a representative level of functioning relative to the general population on the dimensions of intellectual functioning and adaptive skills in order to determine initial or continuing eligibility for school or community services.

Mental Retardation: Definition, Classification and Systems of Support, 1992, page 35).

It is reasonable to clarify that this subpart does not require assessment when agreed to as being unnecessary or when there has been an assessment in the last 12 months because Minnesota Statutes, section 256B.092, subdivision 1, provides that:

> Nothing in this section shall be construed as requiring: (1) assessment in areas agreed to as unnecessary by the case manager and the person, or the person's legal guardian or conservator, or the parent if the person is a minor, or (2) assessments in areas where there has been a functional assessment completed in the previous 12 months for which the case manager and the person or the person's guardian or conservator, or the parent if the person is a minor, agree that further assessment is not necessary.

It is also consistent with statute to allow assessment

information from other providers to be used in lieu of requiring additional assessments. This provision is further reasonable because it avoids unnecessary duplication of effort.

It is necessary and reasonable to require that in cases of public guardianship, the case manager must seek authorization from the Department for a waiver of any assessment requirements to assure compliance with statute and to avoid any conflict of interest. Minnesota Statutes, section 256B.092, subdivision 1 specifically requires that: "For persons under state guardianship, the case manager shall seek authorization from the public guardianship office for waiving any assessment requirements."

Since in some county agencies the same staff person may be serving as both the case manager and the guardian, it is necessary to have a separate entity, the guardianship office, make the determination regarding a wavier of assessments to protect the person's best interests.

It is necessary to specify the areas which must be addressed in the assessment so that all factors which may affect the services to be provided are considered. It is reasonable to specify what areas must be addressed in the assessment since such information reflects the major life areas which in turn indicate the areas of the individual's functional needs. The standards contained in items A through J are essentially the same as those previously found in part 9525.0055, subpart 1, items A through J. These items have been changed as indicated in items A through J below. The changes are principally format changes.

Item A: It is necessary to include basic needs as an area of assessment to safeguard the person. This area was not previously included in the assessment required under part 9525.0055. However, during the advisory committee process there was a general consensus among members that assessment of a person's basic needs is essential to a complete assessment. It is reasonable to specify the areas of income or support, money management, shelter, food, clothing, and assistive technology as basic needs essential to one's continued well being that must be addressed before other more individualized needs can be addressed. In particular, it is important to address those adaptations or assistive technologies that may be used to make the physical environment meet the person's needs.

The significance of the assessment and provision of assistive technologies is inherent in the Developmental Disabilities Act, which defines assistive technology as:

> [T] systematic application of technology, engineering

> methodologies or scientific principles to meet the needs of, and address the barriers confronted by persons with developmental disabilities in areas including education, employment, supported employment, transportation, and independent living and other community living arrangements. Such term includes assistive technology devices and assistive technology services.

42 U.S.C. §6001(21).

Item B: Item B contains the assessment requirement previously found in part 9525.0145, item A. This item has been changed to specify the health and safety areas of physical and dental health, vision, hearing, medication management, mental health and emotional well-being, and ability to keep oneself safe. This specification is necessary for clarification regarding those aspects of health and safety which must be specifically addressed in the assessment. It is particularly important that health and medical areas be assessed because persons with mental retardation or related conditions have a higher incidence of health and medical needs and complications per capita than does the general population.

Item C: Item C contains the assessment requirement previously found in part 9525.0145, subpart 1, item D. The change is necessary and reasonable to accomplish the renumbering and reformatting of the rule parts.

Item D: Item D contains the assessment requirement previously found in part 9525.0145, subpart 1, item F. The change is reasonable to accomplish the renumbering and reformatting of the rule parts.

Item E: Item E contains the assessment requirement previously found in part 9525.0145, subpart 1, item E. It has been changed to delineate the specific self-care skills which the assessment must address. It is reasonable to specify these assessment areas for the reasons stated in item B above.

Item F: It is necessary to assess the person's home living skills because assessment of these skills is an integral part of determining a person's ability to function in the community. It is reasonable to specify the home living skills listed because these are all skills we each use in our everyday life. Specification of these home living skills is further reasonable for the reasons stated in item B above.

Item G: Item G contains the assessment requirement previously found in part 9525.0145, subpart 1, item G. This item now

specifies the required areas which must be addressed in the assessment of a person's community use needs. Specification of these community use skills is further reasonable for the reasons stated in item B above.

Item H: Item H contains the assessment requirement previously found in part 9525.0145, subpart 1, item H. This item clarifies that the assessment must address employment as well as vocational needs.

Item I: Item I contains the assessment requirement previously found in part 9525.0145, subpart 1, item C. This item clarifies that the assessment must address the person's educational as well as cognitive needs. The current requirement simply refers to intellectual functioning, which has resulted in confusion and sometimes failure to address the person's educational needs.

Item J: This item contains the same requirement previously found in part 9525.0145, subpart 1, item J. The change is necessary to accomplish the renumbering and reformatting of the rule parts.

These standards are reasonable because they are consistent with the definitional components of adaptive skills commonly-accepted by the field of developmental disabilities. The AAMR states that adaptive skill disabilities derive from disabilities in practical and social intelligence. The AAMR defines "practical intelligence" as:

> [T]he ability to maintain and sustain oneself as an independent person in managing the ordinary activities of daily living. It includes the capacity to use one's physical abilities to achieve the greatest degree of personal independence possible. Practical intelligence is central to such adaptive abilities as sensorimotor skills, self-care (sleeping, bathing, toileting, eating and drinking) and safety skills (avoiding danger and preventing self-injury). It is also important for other adaptive abilities such as functional academics, work, leisure, self-direction, and use of community.

Mental Retardation: Definition, Classification, and Systems of Support, American Association on Mental Retardation, 9th Edition, 1992, page 15.

The AAMR defines "social intelligence" as:

> [T]he ability to understand social expectations and the behavior of other persons and to judge appropriately how to conduct oneself in social situations. The principle

> components of social intelligence are social awareness and social skill. More specifically, they include social comprehension, insight, judgment and communication. Social intelligence is central to such adaptive abilities as social skills, communication, work, leisure, home living and use of the community.

Id.

Items A through J are further reasonable because they are consistent with commonly accepted methods of gathering information about a person's skills and needs. In terms of assessment methodology, the ACDD notes that the assessment process "may include a variety of methods to gather information for program planning and support of the individual, including formal standardized testing; informal rating scales; observation of the individual in various natural environments; and interviews with the individual, family, and others in the person's residential, work, or educational setting."

Interpretation and Guidelines for Services for People with Developmental Disabilities, 1990, page 129.

While intellectual functioning is the first dimension of the definition of mental retardation, the second dimension is the existence of disabilities in adaptive skills. Requiring assessment in the areas delineated in items A through J is reasonable because these are the adaptive skill disability areas commonly identified by experts in the field of developmental disabilities, as having the most significant impact on functioning. For example, the *Scales of Adaptive Behavior* assess the following adaptive skill areas: 1) gross motor skills; 2) fine motor skills; 3) social interaction; 4) language comprehension; 5) language expression; 6) eating and meal preparation; 7) toileting; 8) dressing; 9) personal self-care; 10) domestic skills; 11) time and punctuality; 12) money and value; 13) work skills; and 14) home and community orientation.

It is reasonable to delineate the specific adaptive skill areas to provide further clarification of the concept of adaptive behavior. According to the ACDD, the assessment process "should focus on those skills and supports present, needed, or desired in order for the individual to function in the community as independently as possible, and on factors in the environment that require modification in order for an individual to meet his or her personal goals." *Id.*

Subpart 2. **Review of person's needs for services and supports.** This subpart is necessary to clarify when a review of the

person's needs for services and supports is needed. It is reasonable to require at least an annual determination because a person's needs could change significantly over the course of a year. Further, updated information is necessary for the annual review of the individual service plan. It is further reasonable to require that the case manager reviews assessment information on an ongoing basis to assure that changes in a person's needs are addressed in a timely manner. In some cases, a person's needs may change well in advance of the annual review date. Therefore, in order to facilitate the provision of adequate services and supports, it is reasonable to address the need for change when such concerns arise.

It is reasonable to require that the service planning team review the assessment annually and before modifications are made to the person's individual service plan to clarify that their input must be obtained. This requirement is reasonable to best meet the person's individual needs because members of the service planning team may have access to information about changes in the person's assessed needs of which the case manager may not be aware.

It is necessary and reasonable to require the case manager to coordinate the performance of the assessments because coordination is one of the primary roles of the case manager. Minnesota Statutes, section 256B.092, subdivision 1a(b)(5) specifies coordination of services as one of the case management service responsibilities. It is further reasonable to clarify that this subpart does not require duplication of assessment responsibilities fulfilled by providers to avoid unnecessary duplication of effort as well as excessive assessment of the person. Requiring that the case manager coordinate the assessment process facilitates the most efficient approach in terms of time and staff resources.

Subpart 3. Individual service plan development. This subpart modifies the requirements previously found in part 9525.0075. The changes are necessary to implement Minnesota Statutes, section 256B.092, subdivision 1b, which identifies the required components of the individual service plan. This subpart is further necessary to identify the persons who are to participate in the planning process and development of the individual service plan, as well as to identify the required components of the individual service plan. The importance of the team approach to service planning is illustrated in the following remarks of the ACDD:

> Each team member uses the skills, competencies, insights, and perspective from the member's own experience to develop the individual's plan.

Standards and Interpretation Guidelines for Service for People with Developmental Disabilities, Accreditation Council on Services for People with Developmental Disabilities, 1990, page 125.

It is necessary and reasonable to allow individual service plans to be completed on forms developed for interagency planning, such as transition and individual family service plans, to avoid the development of unnecessary and duplicative plans for the person. It is reasonable to allow these plans to substitute for the individual service plan as long as the alternative plan includes all of the necessary components in order to avoid unnecessary duplication of effort and use of staff time.

It is necessary and reasonable to provide that service plans containing the components listed under items A through J meet the requirements of parts 9550.0010 to 9550.0092 (Rule 160), and that another service plan is not required in such cases. During the advisory committee process, a number of members expressed concern that confusion exists with respect to the relationship of the individual service plan requirements under current parts 9525.0015 to 9525.0165 and parts 9550.0010 to 9550.0092, which governs the administration of community social services. Part 9550.0090 requires the development for the provision of community social services agreed upon by the local agency and the recipient or recipient's representative. The requirements delineated under items A through J are consistent with those requirements specified under part 9550.0090, subpart 2. Therefore, an individual service plan developed under this subpart would meet the requirements of part 9550.0090. Since such a plan would satisfy the requirements of both rules, it would be both unnecessary and inefficient to require the development of another plan.

Items A through J are reasonable because they are consistent with the components required under Minnesota Statutes, section 256B.092, subdivision 1b (1)-(10).

Item A: Identification of the person's needs and preferences for services is a required component of the individual service plan according to Minnesota Statutes, section 256B.092, subdivision 1b(2). This requirement is reasonable because the individual service plan should be focused on the person's preferences for services. Service types and availability must be explained adequately to the person and to their legal representative, if any, in order to facilitate an informed choice. Persons who are not able to make an informed choice are still frequently able to communicate their preferences. Case managers, service providers,

and guardians need to be sensitive to this and make efforts to determine preferences of the person. However, this does not constitute informed choice, and if a person is not able to make an informed choice regarding services, a legal representative must be secured to assure informed choice can be made.

Item B: Under Minnesota Statutes, section 256B.092, subdivision 1b(1), the person's need for service is a required component of the individual service plan. This requirement is reasonable because assessment information included in the person's individual service plan should reflect the results of the assessment of a person's need for service. In order to best meet the person's needs, the case manager and providers need to learn from assessment what services are needed and why they are needed. The results of the assessment must also include identification of service needs that are or will be met by natural supports and services that will be provided through community resources. Persons with disabilities should have access to these same resources and be included in the community activities and services. Item B informs case managers that it is their responsibility to assure resources are identified and that assistance in access in made available.

Item C: Long- and short-range goals are a required part of the individual service plan under Minnesota Statutes, section 256B.092, subdivision 1b(3). This requirement is necessary to clarify what the expected goals are for the person. Requiring the identification of long-range goals and evaluating services based on those goals is an important component of a service system responsive to individual needs. It is reasonable to state the long-tern goals in the individual service plan because the individual service plan is the key plan used to establish the overall direction that services shall take and establishes a basis for the service providers in their development of short-term goals for the individual program plan.

It is important to note that a long-range goal does not imply being locked into specific timelines. A long-range goal for one person may be five years and for another person, two years. Service planning should allow for flexibility in order to address people's needs and goals in a more individualized manner.

Item D: Minnesota Statutes, section 256B.092, subdivision 1b(4) specifies that the individual service plan must identify specific services and the amount and frequency of those services. This item is reasonable because it emphasizes that the specific services provided, and the amount and frequency of those services, are to be based on assessed need, preferences and available resources. It is reasonable to include the type,

amount, and frequency because these variables affect who can provide the services, the effectiveness and cost of services provided, and should be given careful consideration when authorizing services. Specifying type, amount, and frequency in the individual service plan provides the case manager with criteria for determining whether the provider is providing services that meet the person's needs.

Item E: According to Minnesota Statutes, section 256B.092, subdivision 1b(4), the individual service plan must also identify other services the person needs that are not available. This information should then be added to the county waiting list for services so that this information can be more effectively used in the CSSA planning process. This item is necessary to address the unmet needs of persons with mental retardation or related conditions in the county. It is reasonable to link the planning and development process to the individual service plan to encourage development based on identified service needs. To develop meaningful service plans for individuals, it is important to look at all the person's needs, not just the needs for which services are currently available. It is consistent with Minnesota Statutes, section 256B.092, as well as the Developmental Disabilities Act of 1984, section 122(5)(b), to require the individualization of services to person with mental retardation. Since individuals needs vary greatly, in some cases it will not be possible to meet those needs without developing new services. This requirement provides a mechanism for identifying and developing these needed services.

This requirement is further reasonable because it does not mandate that counties immediately provide services which are not currently available, but requires a plan for addressing situations for which there are no immediate services available.

Item F: Minnesota Statutes, section 256B.092, subdivision 1b(5) specifies that the individual service plan must identify the need for an individual program plan to be developed by the provider. Under Minnesota Statutes, section 256B.092, as amended, case managers are no longer responsible to develop a habilitation component of the individual service plan. Case managers now must identify in the individual service plan, the person's need for an individual program plan to be developed by the provider. The case manager will participate as a member of the interdisciplinary team assembled by the provider for the purposes of developing the individual program plan. (Not every person or family will need or require an individual program plan. Some families may only want respite care or help in accessing services, and may have their habilitation needs met in another setting or at home). In addition to this, the individual service

plan must identify additional assessments that will be the responsibility of the provider to do or arrange to be done. For example, a person may have an assessment done upon service entry that identifies a need for services in the area of communication. The person may enter service, but in order for a good communication program to be developed, the provider may need more specific, functional assessments to be completed at a later date.

Item G: Item G is necessary because the federal ICF/MR regulations as well as parts 9525.2000 to 9525.2140 require the identification of additional assessments to be completed or arranged by the provider after service initiation. The Code of Federal Regulations, title 42, section 483.20 requires that: "The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity."

Item H: Item H is reasonable because Minnesota Statutes, section 256B.092, subdivision 1b(6) identifies the provider's responsibility to implement the individual service plan and make recommendations for modifications to the plan. It is important to remember that case managers are also service providers and as such, have responsibilities which must be included in the service plan. In order to assure provider feedback to the case manager, it is important that the provider make recommendations to the case manager regarding the service plan when the provider identifies the need for modifications.

Item I: Minnesota Statutes, section 256B.092, subdivision 1b(7) requires that the individual service plan must include a notice of the right to request a conciliation conference or a hearing under section 256.045. It is reasonable to require the individual service plan to include such a notice to assure the person is informed of their due process rights.

Item J: Item J is reasonable because Minnesota Statutes, section 256B.092, subdivision 1b(8) requires that the individual service plan must be agreed upon and signed by the person, the person's legal guardian or conservator, or the parent if the person is a minor, and the authorized county representative. It is reasonable to require the signatures of the person, the person's legal representative, and the case manager because the individual service plan is in essence an agreement between the person, the person's parent if the person is a minor, the legal guardian and the county agency. Therefore, it is important that the agreement be signed and dated by all parties. However, this does not mean that if there are areas of disagreement that no plan can be developed. A plan can be developed that incorporates the items agreed to, and other services not agreed to could be identified

separately and dealt with through conciliation or appeal.

Item K: Item K is necessary because Minnesota Statutes, section 256B.092, subdivision 1b(9) requires that if the person has overriding medical needs that impact the provision of services, the plan must be reviewed by a health professional. This health professional could be from a public agency, or the person's personal or provider's health care professional. This requirement is reasonable because if the person has health needs that may impact or interfere with program or care, the providers need to be aware of these, plan for them, and have some skill or receive training in these areas. Since case managers are usually not skilled health care individuals, review of the plan by a health professional assures planning in such a way as to protect the person's health and safety. It is anticipated that the nurse participating as a member of the screening team for persons with overriding medical needs, would be utilized where appropriate, since screening is an activity of service planning. However, when a family is purchasing services through the family support program or a county family subsidy "grant", the family is usually free to purchase services from a provider of their choice and are not required to have their plan reviewed by a health care professional.

Subpart 4. Other service plans. This subpart is necessary to implement Minnesota Statutes, section 256B.092, subdivision 1g, which provides that:

> Unless otherwise required by federal law, the county agency is not required to complete an individual service plan as defined in subdivision 1b for:
> (1) persons whose families are requesting respite care as a single service for their family member who resides with them, or whose families are requesting only a family subsidy grant and are not requesting purchase or arrangement of other habilitative or social services; and
> (2) persons with mental retardation or related conditions, living independently without authorized services or receiving funding for services at a rehabilitation facility as defined in section 268.01, subdivision 6, and not in need of or requesting additional services.

It is reasonable to amend rules to assure consistency with statute. It is reasonable to reference Rule 160 to clarify that the individual service plan requirements of Rule 160 must still be met, notwithstanding the exception contained in this subpart.

Subpart 5. Identification of service options and providers.

This subpart is necessary to implement statute. Minnesota Statutes, section 256B.092, subdivision 1a(b)(3), provides that case management administration and service activities provided to or arranged for a person include assisting the person in the identification of potential providers. It is reasonable to require the case manager to identify items A through D for the service planning team because identification of such information facilitates a service system in which people in need of services are made aware of, helped to locate, and given the opportunity to obtain the services they need.

It is reasonable to require the case manager to indicate in the person's individual service plan the inability to locate appropriate service providers in order to fully consider the entire range of the individual's needs. This requirement is further reasonable because it facilitates sensitivity to the wishes and desires of the individual and the family.

It is reasonable to require case managers to follow county waiting list procedures in order to maximize the effectiveness of community social service planning activities by requiring current and accurate documentation of needs for service which have been identified as existing in the community.

Surveying existing providers to determine which providers, if any, are available to provide the services specified in the individual service plan is a reasonable method of procuring the best possible provider because it increases the case manager's awareness of available resources. Developing a request for proposals for the specified services is a reasonable way to increase the pool of available providers and develop new services to meet identified needs. It is reasonable to allow the use of a request for proposals at the county board's discretion because in some cases it may not be timely or cost effective to use the request for proposals process.

Subpart 6. Assisting the person to access services.

This subpart is necessary to implement statute. Minnesota Statutes, section 256B.092, subdivision 1a(b)(4) provides that case management service activities provided to or arranged for the person include assisting the person to access services. Items A through E are reasonable because they specify activities and steps that are essential to best meet the individual service needs of the person.

Item A: Under this item it is necessary for the case manager to coordinate the application process and preplacement planning activities to assure that the person has been afforded the

opportunity to apply for as well as visit selected services before making a service selection. Information obtained by the person during site visits assists the person in making an informed choice among service options.

Item B: Item B is necessary because financial arrangements, contracts or provider agreements must be in place before service delivery begins. Such agreements or arrangements are often dependent on federal regulations as well as funding. This requirement is reasonable because it avoids the selection of a service which is not feasible due to inadequate or lack of financial arrangements.

Item C: Under item C, it is necessary and reasonable that the case manager advocate to the county for services that fit the person's needs to facilitate the selection of an appropriate service and a placement that is in the best interest of the person. According to the ACDD:

> Once the individual or family has requested services, the activities related to service selection should be conducted with the entire range of the individual's needs in mind and not only in relation to those services offered by a given agency.

Standards and Interpretation Guidelines for Services for People with Developmental Disabilities, 1990, page 76.

The ACDD also stresses that policies relating to assisting individuals to identify and access needed services should be sensitive to the wishes and desires of the individual and the family.

Item D: This item is necessary to assure that the person is provided services identified in the individual service plan. According to Minnesota Statutes, section 256B.092, subdivision 1b (4), the individual service plan must identify specific services to be provided to the person based on assessed needs, preferences, and available resources. This provision further requires that the individual service plan must also specify other services the person needs that are not available. According to the ACDD:

> Protocols for collecting information and handling requests should be designed for the planning and coordination of services and for the identification, not only of available services, but also those that are needed and not provided in the community.

Id. at 73.

Subpart 7. Coordination of service delivery.

This subpart is necessary to implement the requirements of the case management statute. Minnesota Statutes, section 256B.092, subdivision 1a(b)(5) requires that case management services provided to or arranged for the person must include coordination of services. It is reasonable to require that the case manager assure that services are being implemented in compatible ways, that the various services providers are communicating sufficiently to assure coordinated approaches to services among providers, and to assure that services are consistent with the person's individual service plan.

The coordination function is referred to throughout the rule parts and is integral to the understanding of the case manager's responsibilities. This subpart is reasonable because the requirements are consistent with national, state-of-the-art standards regarding the role of the agency in the service delivery system. The ACDD defines "coordination" as the following:

> Coordination refers to the process of securing various resource and arranging them in sequence and combination to accomplish a given purpose. Coordination within the service delivery system involves initiating and maintaining effective working relationships among its various parts as well as the development and maintenance of informal support networks for individuals.

Id. at 63.

Further, in terms of coordination of the individual plan, the ACDD remarks that "coordination includes obtaining direct services, linking services, identifying gaps in services, monitoring the progress of the individual, and advocating for services. *Id.* at 223.

The ACDD also stresses the participation of each service provider in coordinating the delivery of services and states that, "staff of all agencies providing any component of service required by the plan take an active role in ensuring communication and overall plan coordination." *Id.*

Subpart 8. Monitoring and evaluation activities. This subpart modifies the requirements previously found in parts 9525.0115 and 9525.0125. The changes are necessary to implement Minnesota Statutes, section 256B.092, subdivision 1a(b)(6), which requires

that case management services must include evaluation and monitoring of the services identified in the plan.

This subpart is necessary to clarify what standards constitute monitoring functions and what must be reviewed. Monitoring of services is essential in maintaining effective, quality services. Items A through F are reasonable because they are consistent with Minnesota Statutes, section 256B.092, subdivision 1e(b), which requires that:

> The case manager shall monitor the provision of services:
> (1) to assure that the individual service plan is being followed according to paragraph (a);
> (2) to identify any changes or modifications that might be needed in the individual service plan, including changes resulting from recommendations of current service providers;
> (3) to determine if the person's legal rights are protected, and if not, notify the person's legal guardian or conservator, or the parent if the person is a minor, protection services, or licensing agencies as appropriate; and
> (4) to determine if the person, the person's legal guardian or conservator, or the parent if the person is a minor, is satisfied with the services provided.

It is necessary to determine the adequacy of the services authorized for the person and whether the goals and objectives specified in the individual service plan and individual program plan are adequately meeting the needs of the person. It is reasonable to require monitoring to determine if the funds spent on services are being used prudently. It is further reasonable to evaluate whether the authorized services should be modified to facilitate more effective use of funds to meet the needs of persons with mental retardation or a related condition. Approximately 500,000 million dollars in federal, state, and local money is spent each year to serve persons with mental retardation or related conditions in Minnesota. It is sound public policy to require monitoring of expenditures of this magnitude.

It is necessary and reasonable to assure that interdisciplinary team members are notified in cases of inadequate services or dissatisfaction with services in order to facilitate the provision of services that meet the person's individual needs and best interests. It is reasonable to allow the case manager and the provider at issue to first address and resolve the situation. At this level, the provider may be able to readily develop a resolution which meets the person's needs and eliminates the dissatisfaction or inadequacy of the services. Further, at this

level any concerns resulting from lack of information or misinformation can be clarified and resolved. If the issue can not be resolved by the case manager and the provider in question, it is necessary and reasonable to consult with interdisciplinary team regarding the matter. The interdisciplinary team members are responsible for the planning of services for the person and in such roles need to be informed about any unresolved issues regarding the provision of services. During the advisory committee process, a number of members stressed that it is important to attempt to resolve concerns at an initial level rather than immediately referring matters in order to avoid an unnecessary and burdensome process. However, if an issue regarding the provision of services remains unresolved after preliminary measures have been attempted, it is certainly necessary that the case manager notify the relevant licensing and certifying agencies in order to protect the health and safety of the person(s) receiving services.

9525.0065 [See repealer]. The deletion of this part is essentially a format change. The screening team standards and requirements have been moved to part 9525.0016, subparts 7 through 10, under case management administration responsibilities and modified as indicated above. The deletion of this rule part is reasonable to accomplish this format change.

9525.0028 QUALITY ASSURANCE.

This part is necessary to inform case managers, county boards and other persons affected by parts 9525.0004 to 9525.0036 of requirements for compliance with the rule as well as how the provision of case management will be evaluated. A mechanism for the enforcement of parts 9525.0004 to 9525.0036 is necessary to facilitate consistent application of the standards as well as to protect the health, safety and rights of persons with mental retardation or related conditions. Proposed parts 9525.0004 to 9525.0036 represent the Department's intent to emphasize outcomes while retaining some process requirements to the extent necessary for quality assurance and monitoring.

The specific requirements of technical assistance and monitoring and evaluation contained in this part are reasonable because they refer to the requirements under Minnesota Statutes, section 256E.05 which authorizes the Commissioner to supervise county agencies. This provision stresses technical assistance as well as monitoring and evaluation by the Department. Specifically, Minnesota Statutes, section 256E.05, subdivision 3 requires that the Commissioner shall:

> (d) Provide training, technical assistance, and other support services to county boards to assist in needs assessment, planning, implementing and monitoring social services programs in counties;
> (e) Design and implement a method of monitoring and evaluating social services, including site visits that utilize quality control audits to assure county compliance with applicable standards, guidelines, and the county and state social services plans.

With regard to evaluation, outcome evaluation asks whether or not the results of the services provided attained the goals or planned outcomes of the program. Tanya Suarez, Ed.D., in a paper discussing evaluation by the federal government, points out that the most significant outcome of evaluation is improved programs. Ms. Suarez illustrates the importance of the role of evaluation in her following remarks:

> Mere consideration of a questions such as "What is it that you intend for your program to do for its participants?" or even more basically, "Who are the intended participants in your program or recipients of your services?" often leads to greater specificity and clarity regarding programs and their services.

Living with the Mixed Message: Evaluation Requirements on the Practice of National Early Childhood Technical Assistance System, University of North Carolina at Chapel Hill, 1990.

The need and reasonableness for shifting away from a process orientation to an outcomes focus is discussed in detail in part 9525.0030, subparts 2 and 3 of this statement of need and reasonableness. Since parts 9525.0004 to 9525.0036 place an emphasis on the outcomes of case management provided to persons with mental retardation or related conditions, it is necessary and logical that the monitoring and evaluation of case management provided by counties focus on outcomes as well.

As discussed in part 9525.0008, subpart 2, the decision by the ACDD to shift to outcome-based performance measures is consistent with the general trend toward refocusing services for persons with disabilities from the developmental model to the supports paradigm. As stated by the National Association of Mental Retardation Program Directors, the supports model "itself is premised on tying the provision of supports and services directly to achieving critical outcomes of the quality of life areas the ACDD measures assess. In addition, ACDD's new framework recognizes the value of adopting person-centered quality assurance/quality enhancement strategies rather than program-

centered approaches which typically do not place sufficient emphasis on asking the customer what he or she thinks or the services and supports being furnished." *The Community Services Reporter*, Bulletin No. 92-11, May 22, 1992, National Association of State Mental Retardation Program Directors, page 4.

Another example of the trend toward focusing on outcomes is the National Association of Public Child Welfare Administrators (NAPCWA) Forum which was held on December 9, 1991, for the purpose of bringing child welfare administrators from across the country to discuss the issue of client outcome measures. The National Resource Center on Child Abuse and Neglect distributed an assessment during the Forum which yielded the following results. First, ninety percent of the respondents indicated that their agency uses or is considering using client outcome measures at this time. Second, respondents identified their primary goal in using outcome measures as improving outcomes for children and families. Further, sixty-four percent of the respondents had used specific instruments to measure client outcomes, and the majority expressed satisfaction with the instruments they had used. In its summary, the National Resource Center on Child Abuse and Neglect also noted that "it is clear that a significant number of agencies are moving forward with implementing outcome measurement despite a perception of inadequate resources." *Summary Findings from the Assessment of Client Outcome Measurement*, NAPCWA Forum, December 9, 1991, Prepared by the National Resource Center on Child Abuse and Neglect, operated by the American Human Association.

It is necessary and reasonable to refer to the statutory requirement that the county must develop a corrective action plan in cases of noncompliance in order to facilitate compliance with statute and rule, to provide counties with notice of their responsibility under the law, and to protect the interests of persons receiving case management. It is further reasonable to refer to the Commissioner's authority in cases of noncompliance to ensure the provision of quality services and to protect the persons being served.

9525.0075 [See repealer]. The deletion of this part is essentially a format change. The standards for development of the individual service plan are now found in part 9525.0024, subpart 3 under case management service practice standards. The requirements have been modified as indicated in part 9525.0024, subpart 3, above. The deletion of this rule part is reasonable to accomplish this format change.

9525.0032 HOST COUNTY CONCURRENCE.

This part is necessary to implement Minnesota Statutes, section 256B.092, subdivision 8a. It is reasonable to reference the statutory requirements for host county concurrence to facilitate compliance. This provision is reasonable because it consistent with the legislative intent that there be an agreement between the county of financial responsibility and the county of service. This requirement facilitates persons receiving services that best meet their individual needs while at the same time avoids the unnecessary and cost-ineffective development of programs where an appropriate program exists in a feasible location that can suitably meet the individual's needs.

It is reasonable to provide that failure to notify the county of financial responsibility of concurrence or refusal within the statutorily-required timeline that concurrence will be deemed granted, to give notice and provide clarification to counties. During the advisory committee process, a number of members expressed concern over the confusion that exists with respect to host county concurrence requirements, in particular, what happens if the county of service fails to respond. This part provides the necessary clarification.

9525.0085 [See repealer]. The deletion of this part is essentially a format change. The requirements for arrangement of services is now contained in part 9525.0024, subpart 5 under identification of service options and providers. The provision for surveying existing providers and developing requests for proposals has been incorporated into subpart 3. Authorization of service requirements under part 9525.0085, subpart 2 has been moved to part 9525.0016, subpart 11 and modified as indicated in this statement of need and reasonableness. The repeal of this part is reasonable to accomplish this format change.

9525.0036 NEED DETERMINATION.

Subpart 1. County recommendation for determination of need. This subpart modifies the definition previously found in part 9525.0015, subpart 19. The change is necessarily to accurately reflect the factors upon which the Commissioner's decision on need determination is based pursuant to authority granted by statute. Minnesota Statutes, section 252.28, subdivision 1, provides that:

> In conjunction with the appropriate county boards, the commissioner of human services shall determine, and shall redetermine every four years, the need, location, size, and program of public and private residential services and day training and habilitation services for persons with mental retardation or related conditions.

It is reasonable to reference the authorizing statute in this definition to assure consistency and to inform those affected by the rule of the basis for the Commissioner's authority with regard to need determinations.

It is reasonable to require the use of individual service plans because individual service plans identify met and unmet needs that must be used in CSSA planning. Further, Minnesota Statutes, §256B.092, subdivision 1f requires county agencies to maintain a waiting list of persons with developmental disabilities specifying services needed but not provided.

Subpart 1 is further reasonable because it consolidates the requirements previously contained in part 9525.0145, subparts 2 and 3, thereby streamlining the rule.

Subpart 2. Duties of the commissioner for need determination. This subpart modifies the requirements previously found in part 9525.0145, subpart 5. This subpart is necessary to define the commissioner's role in the need determination process and to notify all interested persons of the factors to be considered by the commissioner in making a determination. It is reasonable for the commissioner to consider the factors specified in items A through G in order to facilitate a determination consistent with policies of the Department as well as the Legislature regarding the provision of services to persons with mental retardation or related conditions. The factors listed in items A through G are similar to those factors which were previously considered under part 9525.0145, subpart 5.

Item A: It is necessary to consider the size of the proposed service to comply with Minnesota Statutes, section 252.28, subdivision 1, which provides that:

> [T]he commissioner of human services shall determine, and shall redetermine at least every four years, the need, location, size, and program of public and private residential services and day training and habilitation services for persons with mental retardation or related conditions.

Minnesota Statutes, section 252.28, subdivision 3, further

provides that:

> (2) In determining whether a license shall be issued pursuant to this subdivision, the commissioner of human services shall specifically consider the population, size, land use plan, availability of community resources and the number and size of existing public and private residential facilities in the town, municipality or county in which the licensee seeks to operate a residence.

(*emphasis added*).

Size is an important factor in determining the most appropriate environment for the person to be served as well as in determining whether the service is the least restrictive and most age-appropriate for an individual. Further, it is necessary that the Commissioner consider size and location to be consistent with Minnesota Statutes, §245A.11, subdivision 4 which requires that:

> In determining whether to grant a license, the commissioner shall specifically consider the population, size, land use availability of community services, and the number and size of existing licensed residential programs in the town, municipality, or county in which the applicant seeks to operate a residential program.

The size of each program is an important consideration in developing a statewide plan for the delivery and funding of residential, day and support services. There is widespread agreement in the field of developmental disabilities that smaller community settings promote more effective programming and a more normalized environment, offering more opportunities for integration into mainstream society. For example, in his recent dissertation submitted to the Temple University Graduate Board, James W. Conroy discusses the results of a longitudinal study of residential programs in Pennsylvania. The study examined quality variations in programs ranging in size from two to eight persons. In his findings, Conroy states, "Both the one-by-one analysis and multiple regressions supported the interpretation that smaller homes were better." *Size and Quality in Residential Programs for People with Developmental Disabilities*, James Conroy, submitted May 1992, page 154. Further, Conroy found smaller homes to be associated with "greater progress in both the adaptive and maladaptive areas." Id; See also, *Relationship of Size to Resident and Staff Behavior in Small Community Residences*, Sharon Landesman-Dwyer, Gene P. Sackette, and Jody Stein Kleinman, American Journal of Mental Deficiency, 1980 (Vol. 85, No. 1); *Research on the Economics of Residential Services in Mental Retardation and Related Fields: An Annotated Bibliography*, Henry

A. Bersani, Jr., Guy Caruso and James A. Knoll, Research and Training Center on Community Integration Center on Human Policy, School of Education, Syracuse University, August 1987.

Item B: This item is necessary in order to allow the state to deny a new service or change in service that does not fall within projected budgetary limits. For example, new ICF/MR development is not within the Governor's budget and would require legislative appropriations. The size of the proposed new ICF/MR may meet statutory and rule requirements, but the costs are not planned for in the budget. The Department, following current policy direction, has projected some new costs for home and community-based waivered services, rather than new ICF/MR development.

The commissioner must operate within the budget established by the Legislature. To authorize increased development without considering cost as a factor would be fiscally irresponsible. Therefore, it is reasonable for the commissioner to consider the costs of the proposed service in relation to the fiscal limitations of the state.

Item C: Item C is necessary to comply with statutory concentration restrictions. Item C is reasonable in order to assure that the Commissioner considers the request with an overall view of the need that exists throughout the state. Minnesota Statutes, section 252.28, subdivision 3, provides that:

> (1) No new license shall be granted pursuant to this section when the issuance of the license would substantially contribute to an excessive concentration of community residential facilities within any town, municipality or county of the state.

This information is reasonable because it assists the commissioner in developing a cost-effective system which meets the needs of persons on a statewide basis.

Item D: Item D is necessary because the provider's ability to deliver the service is an essential component of the service itself. It is reasonable that this information be considered by the commissioner as a basis for determining whether the development of the proposed service is feasible, cost-effective and will best meet the needs of the persons receiving services.

Item E: This item is necessary in order to facilitate compliance with applicable state and federal laws which govern services to persons with mental retardation or related conditions. Minnesota Statutes, section 252A.01, subdivision 1 requires the commissioner to protect the human and civil rights of persons

with mental retardation or related conditions by assuring that such individuals receive the full range of needed services to which they are legally entitled. It is reasonable for the commissioner to consider compliance with applicable law in order to fulfill the commissioner's responsibility under statute and to protect and further the best interests persons being served.

Item F: This item is necessary to implement the Department's directive to emphasize outcomes in rules. See part 9525.0008, subpart 3 for a discussion of the need and reasonableness of this requirement.

Item G: This item is necessary and reasonable because it is consistent with the overall Department policy of normalization regarding services to persons with mental retardation or related conditions. Item G is also consistent with Minnesota Statutes, section 256E.08, subdivision 1(4) which requires "supportive and rehabilitative activities that assist each person to function at the highest level of independence possible for the person, preferably without removing the person from home."

The 30-day turn-around requirement was previously required under part 9525.0145, subpart 6. This requirement is necessary to notify the county of the timeline for the Commissioner's decision on the county board's application. It is reasonable to require the Commissioner to make a determination on the county board's application within 30 days to eliminate undue and burdensome delays in the development of services. It is reasonable to allow the Commissioner up to 30 days in order to provide adequate time in which to carefully consider all of the pertinent factors.

Subpart 3. County review of existing programs. This subpart modifies the requirements previously contained in part 9525.0145, subparts 3, 4, and 7. This subpart is necessary to define the county board's role in the need determination process. This subpart is necessary to implement Minnesota Statutes, section 252.28, subdivision 1 which was amended in 1992 to require that: "The commissioner shall...redetermine at least every four years, the need, location, size, and program of public and private residential services and day training and habilitation services for persons with mental retardation or related conditions." The redetermination was previously required biennially.

This subpart is reasonable because it clarified what is required of the counties in their review of existing programs. It is reasonable to require the county board to be responsible for the review of each service because the county is more familiar with the needs of the clients in its county and with the services available to meet those needs.

It is reasonable to require that the final determination be made by the commissioner because the commissioner is ultimately responsible for the need determination process under Minnesota Statutes, section 252.28. Assigning the final determination responsibility to the commissioner is consistent with the process used for the initial determination. It is reasonable to use the same factors for the redetermination to facilitate consistency between the processes.

Subpart 4. Appeal of the commissioner's determination. This subpart modifies the requirements previously found in part 9525.0145, subpart 9. This subpart is necessary to notify providers that they may appeal the commissioner's decision under Minnesota Statutes, Chapter 14. It is reasonable to simply refer to the fact that appeals are governed by Chapter 14 because this chapter contains the specific procedures for contested cases.

9525.0095 [See repealer]. The deletion of this part is necessary to eliminate unnecessary and duplicative requirements and to streamline the rule. Minnesota Rules, parts 9550.0010 to 9550.0092 (Rule 160), governs the administration of community social services. Specifically, the requirements which govern all social services contracts is contained in part 9550.0040. Since there is already a rule which governs contracts, it is unnecessary and would be duplicative to restate these requirements in the case management rule. The repeal of this part is reasonable in order to eliminate unnecessary duplication.

9525.0105 [See repealer]. The deletion of this part is necessary to be consistent with the case management statute. Amendments made to Minnesota Statutes, section 256B.092, in the 1990 legislative session deleted the individual habilitation plan requirement. Section 256B.092, was subsequently amended in 1991 to require the development of individual program plans by the service providers where the need for an individual program plan has been identified in the individual service plan. Accordingly, the development of an individual habilitation plan is no longer required under law. Therefore, it is reasonable to delete this rule part since it has become obsolete.

9525.0115 [See repealer]. The repeal of part 9525.0115 is necessary to eliminate unnecessary procedural requirements and to streamline the rule. The case manager's monitoring and evaluation responsibilities have been moved to part 9525.0024, subpart 8 and modified as discussed in this statement of need and reasonableness. The frequency of monitoring requirements

previously contained in part 9525.0015, subpart 2, have been deleted in order to afford the counties increased flexibility to meet the individual needs of the persons whom the county is serving.

9525.0125 [See repealer]. The repeal of this part is essentially a format change. As stated above, the monitoring responsibilities of the case manager are now contained in part 9525.0024, subpart 8. The county board procedures previously required under part 9525.0125 have been moved to one of the county board case management responsbilities identified under past 9525.0024, subpart 5. The county board procedures requirements have been modified in subpart 5 to allow counties more flexibility and discretion in establishing procedures which best meet the needs of the persons that particular county serves. Since the service needs of counties vary considerably, it is reasonable and appropriate that the specific content of the county procedures be left to the determination and discretion of that county. The repeal of this part is necessary to accomplish the format change and to eliminate prescriptive procedural requirements.

9525.0135 [See repealer]. The repeal of this part is necessary to accomplish the desired format change of the rule as well as to streamline case management requirements. The case management appeals standards previously contained in this part have been moved to part 9525.0016, subpart 14 as one of the case management administration functions. The appeals requirements have been modified to eliminate unnecessary duplication of statutory language. The case management appeal notice requirements, exceptions to period of notice, and submittal of appeal requirements previously contained in part 9525.0135, subparts 3, 4, and 5 have all been deleted. Part 9525.0016, subpart 14 simply cross-references Minnesota Statutes, section 256.045, which governs the case management conciliation and appeals process.

9525.0145 [See repealer]. The repeal of this rule part is essentially a format change. The need determination requirement have been moved and the rule part renumbered to part 9525.0036. The modifications made to part 9525.0036 are for purposes of streamlining and simplifying the need determination process and eliminating prescriptive procedural requirements. The modifications are also necessary to implement amendments to Minnesota Statutes, section 252.28. Repeal of this part is necessary to accomplish this streamlining and format change.

9525.0155 [See repealer]. Repeal of part 9525.0145 is essentially a format change. The standards for qualification and training of case managers have been moved and the rule part renumbered to part 9525.0012, subpart 6. The requirements have been modified to delete the previous provision for a variance from case manager qualifications because the time period for applicability of the variance expired on January 1, 1987. The repeal of this subpart is necessary to accomplish the format change and to eliminate obsolete rule language.

9525.0165 [See repealer]. Repeal of this part is necessary to reformat and streamline the rule. Compliance and enforcement standards previously contained in part 9525.0165 have been moved and renumbered to part 9525.0028 under the title of Quality Assurance. The provision has been modified to address compliance from a more positive perspective, with a focus on quality services and the provision of technical assistance. This provision has been further modified to eliminate unnecessary duplication of statutory language by cross-referencing Minnesota Statutes, section 256E.05 rather than restating statutory language. Repeal of part 9525.0165 is necessary to accomplish this format change.

TECHNICAL AMENDMENTS

The following amendments are technical in nature only. As discussed in the introduction of this statement of need and reasonableness, a number of other Department rules cross-reference and contain requirements directly related to current parts 9525.0015 to 9525.0165 and parts 9525.0180 to 9525.0190. Since these parts are being repealed and replaced by parts 9525.0004 to 9525.0036, it is necessary to amend the other affected rule parts in a technical manner to assure consistency with the proposed parts as well with the case management statute, Minnesota Statutes, section 256B.092.

The proposed technical amendments can be categorized as follows: 1) amendments of references to current parts 9525.0015 to 9525.0165 or emergency parts 9525.0015 to 9525.0145 to refer to parts 9525.0004 to 9525.0036; 2) amendments of specific references to individual rule parts to refer to the applicable proposed rule part or parts; 3) amendments of the definitions of "person", "person with mental retardation", and "person with a related condition"; 4) repeal of the definitions of and references to the term "individual habilitation plan, and defining and replacing these references with the term "individual

program plan" or "individual service plan"; 5) amendment of the diagnostic requirements for children under the age of five consistent with parts 9525.0004 to 9525.0036; 6) amendment of the need determination references; 7) amendments related to specific rule parts; 8) amendments which update repealed or inaccurate statutory references; and 9) amendments which update references to repealed or inaccurate references to rule parts other than parts 9525.0015 to 9525.0165 or parts 9525.0180 to 9525.0190.

The amendment of the following rule parts is necessary to make other Department rules consistent with the promulgation of parts 9525.0004 to 9525.0036. The specific need and reasonableness for each of the above-referenced technical amendment categories is addressed below with a complete list of all affected rule parts.

I. Technical Amendments Striking References to Parts 9525.0015 to 9525.0165 or Emergency Parts 9525.0015 to 9525.0145 and Inserting References to Parts 9525.0004 to 9525.0036:

It is necessary and reasonable to amend those rule parts which cross-reference parts 9525.0015 to 9525.0165 or emergency parts 9525.0015 to 9525.0145 at the time parts 9525.0004 to 9525.0036 are promulgated to assure consistency among Department rules. The following amendments are technical only and do not substantively change any of the affected rule provisions. These amendments are reasonable to accomplish the renumbering of the case management rule under parts 9525.0004 to 9525.0036 and to avoid confusion by the public. The following is a list of those affected rule parts which the Department proposes to amend simultaneously with the promulgation of parts 9525.0004 to 9525.0036. The following parts are amended by deleting all references to "parts 9525.0015 to 9525.0165" or "parts 9525.0015 to 9525.0145 [Emergency]" and inserting references to "parts 9525.0004 to 9525.0036:"

Part 9503.0055, subpart 3, item G
9503.0055, subpart 6
9503.0065, subparts 3 and 4
9505.0323, subpart 5, item C
9505.0323, subpart 27, item H
9505.2395, subpart 37
9505.2400, subpart 1
9505.2425, subpart 5, item D
9525.0225, subparts 6 and 16
9525.0295, subpart 1
9525.0335, item E
9525.0900, subpart 3
9525.1220, items B and E

9525.1230, subpart 1, items B and H
9525.1240, subpart 1, item E(6) and (8)
9525.1500, subparts 7, 21 and 30
9525.1550, subparts 5 and 6
9525.1560, subpart 5, item B
9525.1630, subpart 2, item A
9525.1820, subpart 1, item B
9525.1830, subpart 1, item B
9525.1900, subpart 1, item F
9525.2010, subparts 7 and 21
9525.2050, subpart 1
9525.2710, subparts 7 and 24
9525.3065, subpart 1
9553.0050, subpart 3, subitems (3) and (4)
9555.5105, subpart 19, item E
9555.5605, subpart 3, item A
9555.6125, subpart 4, item E

II. Technical amendments deleting reference to specific repealed rule parts replaced by reference to entire parts 9525.0004 to 9525.0036.

In the following rule parts, specific references to repealed rule parts are deleted and replaced with a more general reference to parts 9525.0004 to 9525.0036. These amendments are necessary and reasonable to accomplish the renumbering and reformatting of parts 9525.0004 to 9525.0036. It is reasonable to refer to the entire case management rule since services are provided pursuant to the entire rule.

Part 9525.5105, subparts 18 and 19: Reference to repealed part 9525.0075 is deleted and replaced by reference to parts 9525.0004 to 9525.0036.

Part 9555.5605, subpart 1: Reference to repealed part 9525.0065 is deleted and replaced by reference to parts 9525.0004 to 9525.0036.

Part 9555.6167: Reference to repealed part 9525.0075 is deleted and replaced by reference to parts 9525.0004 to 9525.0036.

III. Technical amendments related to the repeal of the definition of "individual habilitation plan", addition of the definition of the term "individual program plan", deletion of references to the term "individual habilitation plan"or "IHP" and insertion of the term "individual program plan" or "IPP", or "individual service plan" or "ISP":

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It is necessary to repeal all rule subparts which define the term "individual habilitation plan" or "IHP", to add the definition of "individual program plan" or "IPP", and to amend all rule parts which refer to the term "individual habilitation plan" or "IHP" by replacing all references to "individual habilitation plan" or "IHP" with the term "individual program plan" or "IPP" in order to be consistent with statute.

Minnesota Statutes, section 256B.092 was amended to provide that a separate habilitation plan is no longer required. Instead, Minnesota Statutes, section 256B.092, subdivision 1b now requires that the individual service plan identify the need for individual program plans. Minnesota Statutes, section 256B.092, subdivision 1c requires that if the individual service plan identifies the need for individual program plans, the case manager shall assure that the individual program plans are developed by the providers. Because the terminology "individual habilitation plan" is no longer used in statute and the governing statute now refers to the terms "individual service plan" and "individual program plan", it is necessary and reasonable to define individual program plan. It is reasonable to amend obsolete rule language to assure consistency with statute and to avoid confusion by the public.

The following affected rule parts contain deletions of the term "individual habilitation plan" or "IHP" replaced by reference to the term "individual program plan" or "IPP" or "individual service plan" or "ISP", or to the repeal of the definition of "individual habilitation plan" or "IHP" or addition of the definition of "individual program plan" or "IPP" as indicated below:

Part 9510.1070, item B
9525.0225, subpart 15 (repeal of definition)
9525.0225, subpart 15a (addition of definition)
9525.0225, subparts 23 and 27
9525.0305, subpart 3, item A
9525.0900, subpart 11 (repeal of definition)
9525.0900, subpart 11a (addition of definition)
9525.1240, subpart 1, item E (2) and (6)
9525.1500, subpart 5, item A
9525.1500, subpart 12
9525.1500, subpart 20 (repeal of definition)
9525.1500, subpart 20a (addition of definition)
9525.1500, subparts 25, 30 and 36
9525.1550, subparts 5 and 8
9525.1560, subpart 4, item D (reference to the definition of individual program plan under part 9525.0004, subpart 11)
9525.1570, subpart 2 and item I

9525.1570, subpart 3, item G
9525.1600, subpart 2
9525.1620, subpart 4
9525.1630 (title)
9525.1630, subparts 1, 2, 3, and 4
9525.1640, subpart 1, item C
9525.1650, subpart 2, item B
9525.1650, subpart 4, item A
9525.1670, subparts 1, 3 and 5
9525.1680
9525.1690, subpart 3
9525.2010, subpart 14
9525.2010, subpart 20 (repeal of definition)
9525.2010, subpart 20a (addition of definition)
9525.2010, subpart 26
9525.2080, item A
9525.2100 (title)
9525.2100, subparts 1, 2 and 3
9525.2100, subpart 4, items C and D
9525.2710, subpart 16 (repeal of definition)
9525.2710, subpart 16a (addition of definition)
9550.0040, subpart 2, item F
9553.0050, subpart 3, item A (2)
9553.0050, subpart 3, item C (5)
9555.5105, subpart 19, item E

<u>IV. Technical amendments related to the deletion of language referring to the individual habilitation plan requirement or IHP:</u>

In the following rule parts, references to language discussing or requiring an individual habilitation plan or IHP is deleted. In the above-referenced rule provisions, the term individual habilitation plan or IHP has been replaced by the term individual program plan, or individual service plan or ISP. However, in the following provisions the references to individual habilitation plan or IHP are no longer necessary and therefore are deleted and not replaced with substitute language. As discussed above, Minnesota Statutes, section 256B.092 no longer requires an individual habilitation plan. Rather, the statute requires the development of an individual service plan, and if identified as necessary, the development of individual program plans. Accordingly, references and rule parts requiring an individual habilitation plan or IHP are now obsolete and inconsistent with statute. These deletions are technical only in nature and are reasonable to assure consistency with statute.

Part 9525.0265, subparts 1, 3 and 7
9525.0265, subpart 8, item B

9525.0305, subpart 3, item A
9525.1630, subpart 2, item B

V. Technical amendments related to children under the age of five or persons otherwise eligible for case management consistent with proposed part 9525.0016, subpart 3:

Amendment of the following rule parts is necessary to be consistent with the case management diagnostic requirements under parts 9525.0004 to 9525.0036. The definition of "person" as proposed under part 9525.0004, subpart 19 defines as "person" as "a person with mental retardation or a related condition or a child under the age of five who has been determined eligible for case management under parts 9525.0004 to 9525.0036." (emphasis added).

Further, proposed part 9525.0016, subpart 3, which requires that in order to be eligible for case management under parts 9525.0004 to 9525.0036, the person must have a diagnosis of mental retardation or a related condition, "or is a child under the age of five who demonstrates significantly subaverage intellectual functioning concurrent with severe deficits in adaptive behavior, but for whom, because of the child's age, a diagnosis may be inconclusive." (emphasis added).

See part 9525.0016, subpart 3 of this statement of need and reasonableness for a discussion of the need and reasonableness of this diagnostic standard. It is reasonable to amend the following rule parts in order to assure consistency between Department rules regarding diagnositic standards.

The following rule parts are amended by adding the phrase "or children under the age of five as specified in parts 9525.0004 to 9525.0036:"

Part 9503.0055, subpart 3, item G
9503.0055, subpart 6

For the reasons stated above, the following rule parts are amended by adding the phrase "or is otherwise eligible for case management as specified in parts 9525.0004 to 9525.0036:"

Part 9503.0065, subpart 1, item A
9503.0065, subpart 3
9555.5105, subpart 18

VI. Technical amendments related to need determination references:

In the following rule parts, the references to part 9525.0145 is deleted and replaced with a reference to part 9525.0036. As stated above, parts 9525.0015 to 9525.0165, including part 9525.0145 which governed the need determination requirements, are being repealed. Proposed part 9525.0036 will govern this need determination process. Accordingly, it is reasonable to amend those rule parts which reference the repealed part to accomplish the renumbering of the rule, and to make the following rule parts consistent with parts 9525.0004 to 9525.0036.

Part 9525.0325, subpart 3, item B
9525.0335, item C
9525.1500, subpart 36
9525.1520, subpart 2, item B(3)
9525.1520, subpart 8, item D
9525.1550, subpart 2, item B
9525.1560, subpart 2

VII. Technical amendments related to the definitions of "person", "person with mental retardation", or "person with a related condition:"

In the following rule parts, the definition of "persons with mental retardation or related conditions" is amended by deleting the reference to the definition of "person" under part 9525.0015, subpart 20 which is being repealed and replacing it with the language "has the meaning given to person under part 9525.0004, subpart 19." This amendment is technical only in nature and is necessary to accomplish the format change and renumbering of parts 9525.0004 to 9525.0036. It is reasonable to amend these rule parts to make other Department rules related to persons with mental retardation or related conditions consistent with parts 9525.0004 to 9525.0036, which governs the diagnostic requirements for mental retardation and related conditions.

Part 9505.2395, subpart 35
9505.3015, subpart 31
9510.1050, subpart 2
9525.0225, subpart 25
9525.2010, subpart 28

For the reasons stated above, the following rule parts are amended by deleting the reference to the definition of mental retardation under part 9525.0015, subpart 20, items A and B, and replacing it with a reference to part 9525.0004, subpart 20 which

contains the definition of "person with mental retardation:"

Part 9525.0900, subpart 16
9525.1800, subpart 19b
9525.3015, subpart 23
9560.0652

Similarly, the following rule parts are amended by deleting specific references to the definition of mental retardation and related conditions under parts 9525.0015 to 9525.0165 and are replaced by the language "a person who has been determined to meet the diagnostic requirements under parts 9525.0004 to 9525.0036."

Part 9525.1820, subpart 1, item B
9525.2710, subpart 24

VIII. Technical amendment related to the addition of the term individual program plan or IPP following references to the provider implementation plan or PIP, and replacement of the term individual habilitation plan of IHP with the terms provider implementation plan or individual program plan or PIP or IPP:

In the following rule parts, the phrase "or individual program plan" or "or IPP" is added following the term provider implementation plan or PIP. This amendment is necessary to clarify that the IPP is considered to be the same as the PIP for purposes of the plan requirements under parts 9525.0215 to 9525.0335. As stated above, Minnesota Statutes, section 256B.092 no longer requires the individual habilitation plan, but does require the development of individual program plan when identified in the person's individual service plan as necessary.

It is reasonable to clarify that the PIP and IPP are the same for purposes of meeting this requirement in order to avoid confusion or the misinterpretation that an additional plan is required. These amendments are technical only in nature and for purposes of clarification. These amendments do not substantively change the content of the following rule parts:

Part 9525.0225, subparts 15a and 27
9525.0265, subparts 1, 3, 5, 6, 7, and 8
9525.0305, subpart 2
9525.0305, subpart 4
9525.0345, subpart 4, item A
9525.0345, subpart 5
9525.1630, subpart 2

IX. Technical amendments related to specific rule parts:

Part 9525.0225, subpart 3: This provision is amended by deleting the reference to repealed part 9525.0015, subpart 3 and replacing it with a reference to the definition of "advocate" under proposed part 9525.0004, subpart 2. This amendment is necessary and reasonable to accomplish the renumbering of parts 9525.0004 to 9525.0036 and to assure consistency between department rules.

Part 9525.0225, subpart 13: This provision is amended by deleting reference to part 9525.0015, subpart 12 and replacing it with a reference to the definition of "host county" under proposed part 9525.0004, subpart 10. This amendment is necessary and reasonable to accomplish the renumbering of parts 9525.0004 to 9525.0036 and to assure consistency between department rules.

Part 9525.0225, subpart 17 and 9525.2010, subpart 23: These provisions are amended by deleting reference to part 9525.0015, subpart 15 and replacing it with the definition of "interdisciplinary team" under part 9525.0004, subpart 14. This amendment is necessary and reasonable to accomplish the renumbering of parts 9525.0004 to 9525.0036.

Parts 9525.0225, subpart 27 and 9525.1500, subpart 30: In these provisions, reference to the provider implementation plan or individual program plan is amended by deleting the term "objectives" and replacing it with the term "goals." This amendment is necessary because the individual service plan, as required by Minnesota Statutes, section 256B.092, contains goals rather than objectives. As stated above, individual habilitation plans are no longer required. Objectives are now specified in the person's individual program plan. It is necessary and reasonable to amend these rule parts to update the terminology and to assure consistency between department rules.

Part 9525.0295, subpart 1: This provision is amended by deleting reference to repealed part 9525.0085, subpart 2 and replacing it with a more general reference to proposed parts 9525.0004 to 9525.0036. This amendment is necessary and reasonable to accomplish the renumbering of parts 9525.0004 to 9525.0036.

Part 9525.0305, subpart 3, item A: This provision is amended by deleting the term "interdisciplinary team" and replacing it with the term "individual service planning team." This amendment is necessary and reasonable to be consistent with the individual service planning requirements under proposed part 9525.0024, subpart 3.

Parts 9525.0900, subpart 3 and 9525.1800, subpart 4a: These provisions are amended by deleting reference to repealed parts 9525.0015 to 9525.0165 and replacing it with reference to the definition of "case management" under proposed part 9525.0004, subpart. These amendments are necessary and reasonable to make these parts consistent with parts 9525.0004 to 9525.0036.

Part 9525.1630, subpart 2: Item A is amended by deleting the reference to repealed part 9525.0075 and replacing it with a more general reference to parts 9525.0004 to 9525.0036. Item B is deleted due to its reference to the obsolete individual habilitation plan requirements. The need and reasonableness of this deletion is discussed earlier in this statement of need and reasonableness. Because of the deletion of item B, the items in this subpart are relettered accordingly. Item D, as relettered, is amended by deleting the reference to repealed part 9525.0105.

Part 9525.2040, subpart 1, item B: The reference to repealed part 9525.0085, subpart 2 is deleted and replaced with a reference to the authorization requirements under proposed part 9525.0016. This amendment is necessary and reasonable to make the Department rules consistent with the renumbering of the case management rule.

X. Technical amendments related to the definition of "case manager:"

In the following definitions, the reference to repealed part 9525.0015, subpart 5 is deleted and replaced with the definition of "case manager" under proposed part 9525.0004, subpart 4. These amendments are necessary and reasonable to make other Department rules consistent with the renumbering of the case management rule.

Part 9510.1020, subpart 2
9525.0900, subpart 4
9525.3015, subpart 6

Similarly, in the following rule parts, the reference to the designation of the case manager under repealed part 9525.0035 is deleted and replaced with a more general reference to parts 9525.0004 to 9525.0036. These amendments are necessary and reasonable to be consistent with the reformatting of parts 9525.0004 to 9525.0036.

Part 9525.0225, subpart 6
9525.1500, subpart 7
9525.2010, subpart 7

9525.2710, subpart 7

XI. Technical amendments related to the term "individual service plan:"

In the following rule parts, the definition of "individual service plan" is amended by deleting reference to the repealed rule parts and replaced with a reference to the definition of "individual service plan" under proposed part 9525.0004, subpart 12. These amendments are necessary and reasonable to be consistent with parts 9525.0004 to 9525.0036.

Part 9525.0900, subpart 12
9525.1210, subpart 9

In the following rule parts, the reference to individual habilitation plan is deleted and replaced with a reference to the individual service plan. As stated above, references to the individual habilitation plan must be deleted because this plan is no longer required under Minnesota Statutes, section 256B.092. It is necessary and reasonable to insert reference to the individual service plan because these rule provisions are discussing the overall service plan for the person and is necessary to be consistent with statute.

Part 9525.0225, subpart 27
9525.1500, subpart 30
9525.2100, subpart 4, item C

XII. Technical amendments related to the addition of agreement to the contract provision:

In the following rule parts, the phrase "or agreement" or "and agreement" is added following the word "contract." This amendment is necessary to be consistent with the language used in parts 9525.0004 to 9525.0036 regarding contracts. The addition of the word "agreement" is reasonable because it clarifies that the contract requirements include other agreements such as three-party agreements under medical assistance requirements.

Part 9525.0335, item E
9525.1550, subpart 6

XIII. Technical amendments related to repealed or inaccurate statutory references.

The following rule parts are amended by deleting reference to the repealed or erroneous statutory cite and replacing it with the correct, current cite. These amendments are technical in nature and are necessary and reasonable to assure consistency between statutes and rules.

Part 9505.0323, subpart 1, item G(3)
9505.2395, subparts 4, 25, 30, 37, 39, and 48
9505.2400, subpart 2, item I
9505.2425, subpart 3, items A and D
9505.3015, subparts 34 and 38
9525.1230, subpart 1, items C, D, and I
9525.1210, subpart 5
9525.1240, subpart 1 and item D
9525.1500, subparts 9 and 10
9525.1550, subparts 9
9525.2010, subpart 10
9525.3015, subpart 29
9525.5105, subpart 11
9525.5605, subpart 11, item C

XIV. Technical amendments related to repealed or incorrect rule parts other than parts 9525.0015 to 9525.0165 or parts 9525.0180 to 9525.0190.

The following rule parts are amended by deleting reference to the repealed or erroneous rule part and replacing it with the correct rule part, or deleting the incorrect cite altogether. These amendments are technical only in nature and are necessary to assure consistency among rules as well as to avoid confusion.

Part 9505.0323, subpart 5, item C
9525.1240, subpart 1, item E(7)
9525.1550, subparts 1, 2 item E, and 10
9525.1670, subpart 2
9525.3015, subpart 9
9553.0050, subpart 3, item A
9555.5105, subpart 26
9555.6125, subpart 9, items A and C

EXPERT WITNESSES

The Department does not intend to have outside expert witnesses testify on its behalf at the public hearing.

SMALL BUSINESSES

The Department has considered the small business consideration requirements under Minnesota Statutes, section 14.115. Proposed parts 9525.0004 to 9525.0036 implement the requirements for case management for persons with mental retardation or related conditions pursuant to Minnesota Statutes, section 256B.092. Adoption of less stringent requirements for small businesses would be contrary to the statutory objectives that are the basis for the proposed rules. In addition, the agency believes that Minnesota Statutes, section 14.115 does not apply to these rules under the exclusion in Minnesota Statutes, section 14.115, subdivision 7, clause (2).

AGRICULTURAL LAND

The proposed rule does not have a direct or substantial adverse effect on agricultural land as defined in Minnesota Statutes, section 17.81, subdivision 3 and referenced in Minnesota Statutes, section 14.11, subdivision 2.

CONCLUSION

The foregoing information demonstrates the need for and reasonableness of the provisions in proposed parts 9525.0004 to 9525.0036. The necessity and reasonableness of the proposed amendments are supported by requirements of Minnesota Statutes and rules, and the authority granted to the Commissioner to adopt rules under Minnesota Statutes, section 256B.092.

DATE: 8 June 93

NATALIE HAAS STEFFEN, COMMISSIONER
Department of Human Services

REFERENCES

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Assessing Children with Low Incidence Handicaps-A Resource Guide, Institute on Community Integration, University of Minnesota, 1991.

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State of Minnesota
Department of Human Services
Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155

July 28, 1993

Ms. Maryanne Hruby
Executive Director, LCRAR
55 State Office Building
St. Paul, Minnesota 55155

Dear Ms. Hruby:

Pursuant to Minnesota Statutes, section 14.131, enclosed is a statement of need and reasonableness relating to Case Management for Persons with Mental Retardation and Related Conditions, proposed Minnesota Rules, parts 9525.0004 to 9525.0036 and related technical amendments.

If you have any questions on the statement of need and reasonableness, please do not hesitate to contact me at 297-1217.

Sincerely,

Laura Plummer Zrust

Laura Plummer Zrust
Rulemaker

Encl.