

STATE OF MINNESOTA
COUNTY OF HENNEPIN

BEFORE THE MINNESOTA
COMMISSIONER OF HEALTH

IN THE MATTER OF PROPOSED
AMENDMENTS TO RULES RELATING
TO CO-PAYMENTS FOR DIAGNOSTIC
EVALUATIONS AND LIMITATIONS
ON REIMBURSEMENT FOR TREATMENT
SERVICES FOR SERVICES FOR
CHILDREN WITH HANDICAPS, AND
ADULTS WITH CYSTIC FIBROSIS
AND HEMOPHILIA, MINNESOTA
RULES CHAPTER 4705.

STATEMENT OF NEED
AND REASONABLENESS

The Minnesota Commissioner of Health (hereinafter "commissioner"), pursuant to Minnesota Statutes, sections 14.05 through 14.12 and 14.22 through 14.28, presents facts establishing the need for and reasonableness of the proposed amendments to rules captioned above.

In order to adopt the proposed amendments, the commissioner must demonstrate that she has complied with all the procedural and substantive requirements of rulemaking. Those requirements are that: 1) there is statutory authority to adopt the rule, 2) all necessary procedural steps have been taken, 3) the rules are needed, 4) the rules are reasonable, and 5) any additional requirements imposed by law have been satisfied. This statement demonstrates that the commissioner has met these requirements.

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1. STATUTORY AUTHORITY.

The commissioner's legal authority for adopting these rules is found in Minnesota Statutes, sections 144.05 through 144.07, and 144.09 through 144.12. Further authority is vested in the commissioner through Minnesota Department of Administration Reorganization Order No. 101 issued pursuant to Minnesota Statutes, section 16.125 (hereinafter "Reorganization Order 101"). Reorganization Order 101 vests within the commissioner the authority to implement Minnesota Statutes, sections 250.05, 256.01, subdivision 2(3) and (5), 256.011, 257.175, and 260.35 insofar as these statutes concern the Services for Children with Handicaps Program.

2. STATEMENT OF NEED.

The legislature has delegated to the commissioner certain responsibilities for administering and supervising programs related to children with handicaps and adults with cystic fibrosis and hemophilia. Minnesota Statutes, section 256.01, subdivisions 2, 3 and 5 (1981). Under the program entitled Services for Children with Handicaps (hereinafter "SCH"), the commissioner reimburses service providers for services authorized by SCH for handicapping conditions in children and for care and treatment of individuals with cystic fibrosis and hemophilia. Such reimbursement is subject to the limitation of available federal and state funds. In order to implement and affectuate these program responsibilities, the commissioner adopted Minnesota Rules, parts 4705.0100 to 4705.1400. These rules established, among other things, provisions for diagnostic evaluations and limitations on reimbursement for treatment.

There is a need to make changes to these rules for the following reasons: First, consistent with the existing provisions related to sharing costs for treatment services, it has been determined that applicants with the financial ability to do so should participate in sharing the costs associated with the provision of diagnostic evaluations. Currently, applicants may not be assessed any out-of-pocket costs for the actual examinations and tests. Second, amendments are necessary to increase the maximum dollar amount that SCH can pay for an applicant's treatment services during a 12-month period. The current limit of \$10,000 has not been increased since it was established in 1979.

The rule-by-rule justification will explain the need for each rule amendment, as well as justifying the reasons for making these changes.

3. COMPLIANCE WITH PROCEDURAL RULEMAKING REQUIREMENTS.

The commissioner has determined that the amendment of the rules in parts 4705.0100, 4705.0300 and 4705.0900 is non-controversial and has elected to follow the procedures set forth in Minnesota Statutes, sections 14.05 through 14.12 and 14.22 through 14.28, which provide for an expedited process for the adoption of non-controversial administrative rule changes without the holding of a public hearing.

Procedural Rulemaking Requirements of the Administrative Procedure Act

The commissioner did not seek information or opinions in preparation for adoption of these rule amendments from sources outside the agency and, therefore, did not publish a notice in the State Register pursuant to Minnesota Statutes, section 14.10.

These rules minimize the duplication of statutory language. See Minnesota Statutes, section 14.07, subdivision 3 (1). The implementation of these rules will not require the expenditure of public money by local public bodies of greater than \$100,000 in either of the two years following their adoption, nor do the rules have any impact on agricultural land. See Minnesota Statutes, section 14.11. The adoption of these rules will not affect small businesses. See Minnesota Statutes, section 14.115, subdivision 7 (b).

Pursuant to Minnesota Statutes, section 14.23, the commissioner has prepared this statement of need and reasonableness which is available to the public. The commissioner will publish notice of intention to adopt the rules without public hearing in the State Register and mail copies of the

notice and proposed rules to persons registered with the Minnesota Department of Health pursuant to Minnesota Statutes, section 14.14, subdivision 1 (a). The notice will include the following statements: a) that the public have 30 days in which to submit comments on the proposed rule; b) that no public hearing will be held unless 25 or more persons make a written request for a hearing within the 30-day comment period; c) giving information pertaining to the manner in which persons shall request a hearing; d) that the rule may be modified if modifications are supported by data and the views submitted; and e) other information required by Minnesota Statutes, section 14.22.

If 25 or more persons submit to the Minnesota Department of Health a written request for a hearing on the proposed rule, the agency shall proceed under the provisions of Minnesota Statutes, sections 14.131 through 14.20 and notice of the hearing shall be published in the State Register.

If no hearing is required, the commissioner will submit the proposed rule and notice as published, the rule as proposed for adoption, any written comments which have been received, and this statement of need and reasonableness to the Attorney General for approval as to their legality and form to the extent that it relates to legality.

These rules shall become effective five working days after publication of a notice of adoption in the State Register.

4. GENERAL STATEMENT OF REASONABLENESS.

The original administrative rules for the Services for Children with Handicaps Program were written in 1979 pursuant to Title V of the Social Security Act, U.S.C., title 47, chapter 7, which authorizes the program, and pertinent state statutes which enable the commissioner to promulgate rules. Amendments, reflecting procedural improvements to the original rules, were adopted in 1986.

The program provides approximately 300 diagnostic clinics per year in order to augment the existing medical expertise in communities across the State and to offer an opportunity to utilize interdisciplinary teams to evaluate children with complicated handicapping conditions such as seizures, cerebral palsy, delayed development, orthopedic conditions, scoliosis, congenital heart problems or heart murmurs, hearing loss or speech and language problems, cleft lip and palate conditions, or other facial or dental anomalies. To date, families have not been required to make any out-of-pocket payment to assist in defraying the cost of providing evaluations in these diagnostic clinics or in other medical care settings. Since the cost of providing diagnostic evaluations has continued to rise over the years, the commissioner believes that it is reasonable for families, who have the financial ability to do so, to assist in defraying a portion of the costs associated with the provision of these services. This approach is consistent with the philosophy embodied in the current requirement that families with an adjusted income above 60 percent of the state gross median income for a household of the same size share in the cost of providing treatment services.

The current \$10,000 per 12-month period limitation on authorization of reimbursement for treatment services was established in 1979. Its purpose was to assure that a few very costly medical procedures, such as liver transplants, would not rapidly deplete the funds available for treatment services and deny a larger number of families the opportunity to receive financial assistance through the Program. This mechanism has worked well in meeting its intended purpose. However, due to the increasing costs of treatment services, more and more families are adversely impacted by the \$10,000 per 12-month period limitation. Therefore, the commissioner believes that it is reasonable to periodically adjust this limit and is proposing that it be increased to \$15,000 per 12-month period. It is estimated that the proposed change would benefit approximately 26 families per year at this time.

Additionally, these amendments are reasonable because they are not unduly burdensome to participants. Also, the commissioner does not exceed the scope of her rulemaking authority as provided by state statute.

5. RULE-BY-RULE JUSTIFICATION.

Part 4705.0100, subp. 10 defines the term "co-payment." It is necessary to include this term in order to distinguish between an applicant's financial participation in the cost of diagnostic evaluation, referred to as "co-payment," and an applicant's financial participation in the cost of treatment services, referred to as "cost sharing."

Part 4705.0300 establishes the co-payment requirement and specifies three levels of co-payment dependent upon an applicant's adjusted gross income, as defined in Part 4705.0100, Subp. 2, and household size. The commissioner believes that it is reasonable to require financial participation in the cost of diagnostic evaluations because the cost of providing these services have continued to rise over the years. Often the evaluations are conducted in clinics organized and operated directly by the Services for Children with Handicaps (SCH) Program. The cost to the SCH Program of providing these services varies with the type of clinic offered.

An average cost for the eight different clinic types is \$120 per patient visit. These costs are determined on the basis of the number of patients seen and the professional staffing pattern at each type of clinic. Experience has shown that the cost of providing similar diagnostic evaluations in other medical care settings is equal to or greater than those in SCH clinics. The new co-payment provision will apply to diagnostic evaluations performed in SCH clinics as well as to those conducted by other medical care providers. At the present time, other medical care providers bill private insurance if the applicant's deductible has been met. Although it has not been used to date, this practice will be adopted by the SCH Program as well for diagnostic evaluations performed in its clinics.

The system proposed by the commissioner to provide for an applicant's financial participation in the cost of diagnostic evaluations will neither create an undue hardship for any applicant nor pose an undue administrative burden on the SCH Program. In order to assure that the imposition of co-payment requirements will not create an economic barrier to the utilization of SCH's diagnostic evaluations, three levels of financial participation are established.

For an applicant whose adjusted gross income is equal to or less than 60 percent of the state gross median income for a household of the same size as the applicant's, no co-payment will be required. Sixty percent of the state gross median income for a household with four members is approximately \$18,500 per year. This percentage was chosen in order to be consistent with the percentage used in the cost-share provisions of part 4705.0600 pertaining to treatment services. However, the commissioner does not propose to use a "SCH adjusted income," as defined in Part 4705.0100, Subp. 24, because of the additional administrative expense required to make these determinations. While this effort is justified for purposes of determining financial participation in the provision of treatment services due to the higher cost of these services and the smaller number of applicants involved, it is not warranted or feasible for diagnostic evaluations where the maximum financial participation is \$15.00 per patient visit and some 5,000 individuals receive evaluations in SCH field clinics alone each year. Instead of requiring applicants to provide copies of their IRS forms and other information as is done for purposes of determining "SCH adjusted income," they will only be required to make a simple statement concerning their family size and estimated "adjusted gross income." A similar process is used to determine income eligibility in certain other public programs, such as the Special Supplemental Food Program for Women, Infants and Children (WIC), and it is the only

information which will be required to determine which level of financial participation is appropriate for each applicant.

For an applicant whose adjusted gross income is greater than 60 percent but less than 100 percent of the state gross median income for a household of the same size as the applicant's, the co-payment amount will be \$7.50 per patient visit. For an applicant whose adjusted gross income is equal to or greater than 100 percent of the state gross median income for a household of the same size as the applicant's, the co-payment amount will be \$15.00 per patient visit. One hundred percent of the state gross median income for a family of four is approximately \$30,800 per year. The upper level of financial participation, \$15.00 per clinic visit, was chosen because it is currently in use by the International Diabetes Center, Park Nicollet Medical Foundation, 5000 West 39th Street, Minneapolis, Minnesota 55416 for their juvenile diabetes clinics which are held in several communities across the state. These clinics have been conducted in cooperation with SCH for a number of years. SCH currently makes the co-payment for families with a previously determined zero cost-share. All other families are required to make the \$15.00 co-payment out-of-pocket and experience has shown that this has not created an economic barrier to utilization of the International Diabetes Center's Clinics. Therefore, it is unlikely that a \$15.00 co-payment requirement will create an undue hardship for any applicant with an adjusted gross income equal to or greater than 100 percent of the state gross median income for a household the same size as the applicants.

Section 505 (D)(i) of Title V of the Social Security Act states:

"(D) if the State imposes any charges for the provision of health services assisted by the State under this title, such charges (i) will be pursuant to a public schedule of charges,"

Inasmuch as Title V funds are used to operate SCH field clinics, the

commissioner must comply with the requirements of establishing a "public schedule of charges" if any charges are to be imposed. While "schedule" is not defined per sé, it is assumed that it would require more than one level of out-of-pocket payment. Therefore, the commissioner proposes to create a level of financial participation between the zero co-pay and \$15.00 co-pay amounts. This middle level, of \$7.50 per patient visit, would be required of an applicant whose adjusted gross income is greater than 60 percent but less than 100 percent of the state gross median income for a household of the same size as the applicant's. For a family of four, this represents an income range between approximately \$18,500 and \$30,800 per year. A co-payment of \$7.50 per patient visit will not create an undue hardship for any applicant in this income range.

Other subparts of Section 505 (D) prohibit the imposition of charges for services provided to low income individuals and require the adjustment of charges in a schedule to reflect considerations pertinent to determining an individual's ability to pay, such as income and family size. The commissioner's proposed provisions for requiring applicant financial participation in the cost of diagnostic evaluations meets both of these requirements. As discussed above, applicants with adjusted gross incomes equal to or less than 60 percent of the state gross median income for a household of the same size as the applicant's are not assessed any out-of-pocket cost. For purposes of determining low income pursuant to Section 505 (D), federal poverty guidelines are used. For a family of four, the federal poverty guideline is approximately \$11,000 per year. This is far less than the approximately \$18,500 which represents 60 percent of the state gross median income for a family of four. Therefore, the requirement that charges not be imposed on low income individuals is

satisfied. Additionally, income and family size is used to determine which level of co-payment applies, satisfying the need to consider an individual's ability to pay.

Part 4705.0900 changes the limitations on authorization of reimbursement for treatment services. The current limit of \$10,000 per 12-month period was established in 1979. Due to the increased cost of medical care services since that time, the limitation is creating difficulty in providing sufficient financial assistance in a number of areas including the following:

1. Coverage of blood products for individuals with hemophilia.
2. Coverage of bronchial drainage for individuals with cystic fibrosis.
3. Coverage of growth hormone.
4. Coverage of orthopedic surgery such as spinal fusion.

Based on a recent review of authorizations issued, it has been estimated that approximately 26 families per year would benefit from an increase in the current dollar limitation. Therefore, the commissioner is proposing to increase the limit to \$15,000 per 12-month period. Although the proposed increase will not be sufficient to fully meet the needs of all of the estimated 26 families, the amount of the increase must be balanced between the number of families who will benefit and the cost of the increase to the SCH Program. If all of the estimated 26 families were to fully utilize the additional \$5,000 per 12-month period, the increase would cost \$130,000 per year to fund. Since this represents a maximum estimated increase in annual treatment costs and since some proportion of this increase will be offset by revenue generated pursuant to the proposed changes in Part 4705.0300, the commissioner believes that the additional costs to the SCH Program will be acceptable.

Date: June 25, 1987

Minnesota Department of Health

Sister Mary Madonna Ashton
Sister Mary Madonna Ashton
Commissioner