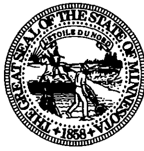

STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

Human Services Building
444 Lafayette Road
St. Paul, Minnesota 55155-38___

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April 1, 1991

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 the proposed adoption of the rule relating to chemical dependency care for public assistance clients, Minnesota Rules, parts 9530.6600 to 9530.6655 and the Consolidated Chemical Dependency Treatment Fund, Minnesota Rules, parts 9530.7000, 9530.7021 and 9530.7031.

If you have any questions on the statement of need and reasonableness, please do not hesitate to contact me at (612) 297-4302.

Sincerely,

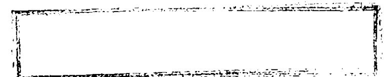
Stephanie L. Schwartz
Rulemaker

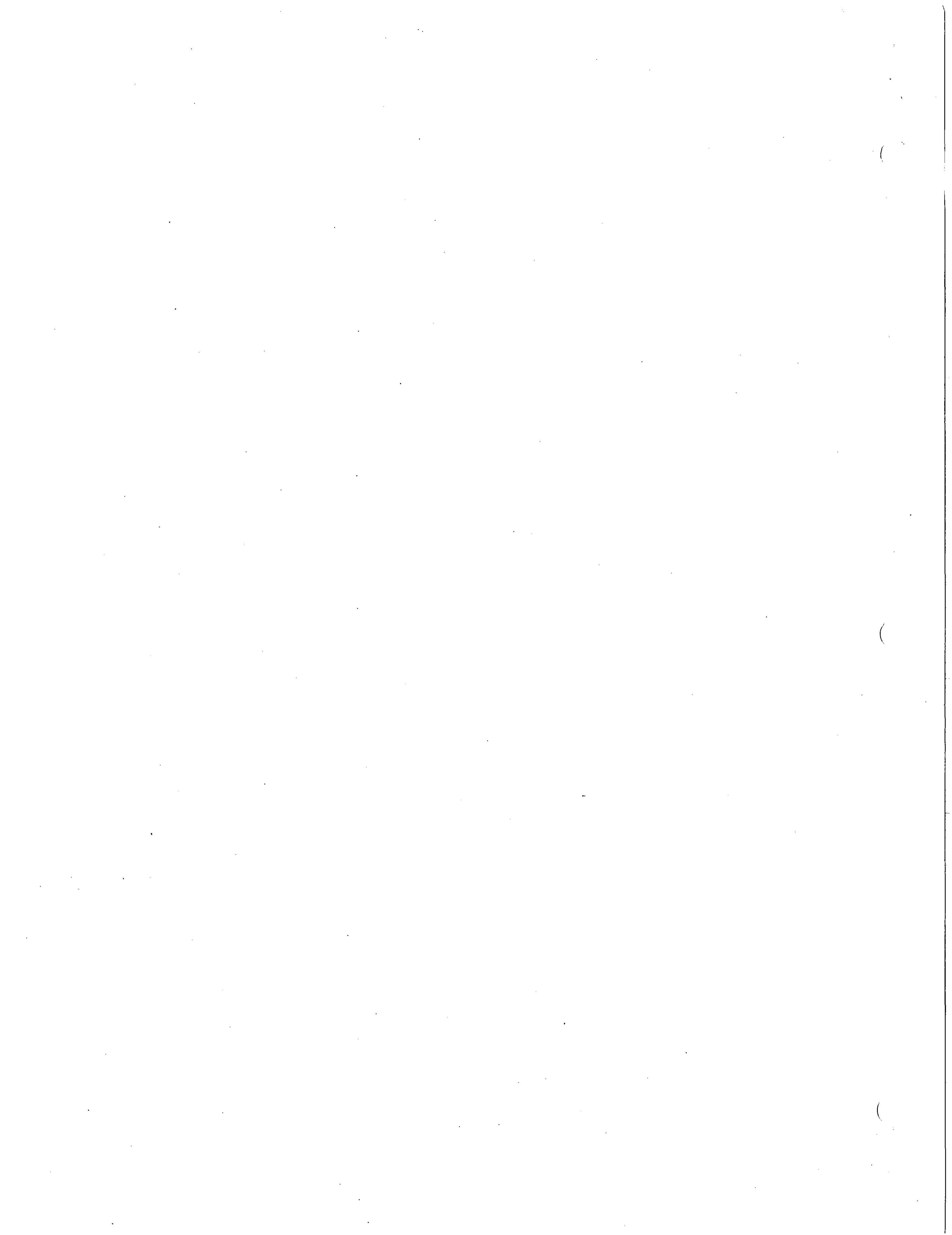
Encl.

AN EQUAL OPPORTUNITY EMPLOYER

The Legislative Commision to
Review Administrative Rules

APR - 3 1991





IN THE MATTER OF THE PROPOSED ADOPTION OF DEPARTMENT OF HUMAN SERVICES AMENDMENTS TO RULES GOVERNING CHEMICAL DEPENDENCY CARE FOR PUBLIC ASSISTANCE RECIPIENTS, MINNESOTA RULES, PARTS 9530.6600 to 9530.6655 AND THE CONSOLIDATED CHEMICAL DEPENDENCY TREATMENT FUND, MINNESOTA RULES, PARTS 9530.7000, 9530.7021, AND 9530.7031.

MINNESOTA DEPARTMENT OF HUMAN SERVICES

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

The proposed amendments affect two series of department rule parts known informally as Rule 24 (Minnesota Rules, parts 9530.6800 to 9530.7030) and Rule 25 (Minnesota Rules, parts 9530.6600 to 9530.6660). Both rules were promulgated in 1987 as mandated by Minnesota Statutes, §254B.03, subdivision 5 (the commissioner shall adopt rules "as necessary") to implement Laws of Minnesota 1986, chapter 394, sections 8 to 20. Additionally, Minnesota Statutes, §254A.03, subdivision 3 requires the commissioner "to establish by rule criteria to be used in determining the appropriate level of chemical dependency care, whether outpatient, inpatient or short-term treatment programs, for each recipient of public assistance" who seeks treatment for chemical dependency and abuse problems.

The legislation that Rules 24 and 25 implement created a Consolidated Chemical Dependency Treatment Fund (CCDTF), allocated funds to counties and Indian reservations for chemical dependency costs, and removed funds for chemical dependency treatment from Medical Assistance, General Assistance Medical Care and General Assistance funds. Rule 24 governs the administration of the CCDTF. Rule 25 establishes the criteria that county social service agencies and reservations apply in determining the appropriate level of care for public assistance recipients (hereinafter referred to as "clients") seeking chemical dependency treatment.

In 1988, the Department began developing amendments to correct problems identified in the first year of implementing Rules 24 and 25. Two of the rule parts in this rulemaking action (parts 9530.6655 and 9530.7021) originated in 1988 along with several other permanent amendments to Rule 24 that have since been promulgated without a public hearing.

In 1990, Minnesota Statutes, §254B.041 (Laws of Minnesota 1990, chapter 568, article 2, section 91) required the Department to amend many of parts 9530.6600 to 9530.7030 by emergency rulemaking. The proposed permanent amendments to parts 9530.6600 to 9530.6650, 9530.7000 and 9530.7031 are, with some

additional technical changes, the same as the legislatively-mandated emergency amendments that have been in effect since August of 1990.

<u>Background on parts 9530.6655 and 9530.7021</u>

As noted earlier, parts 9530.6655 and 9560.7021 were originally part of a larger rulemaking action that included six other parts of Rule 24. When that rulemaking action began in 1988, the Department gathered comment on the proposed amendments by surveying counties about the effectiveness of the CCDTF since its implementation and by presenting drafts of the proposed amendments to the Alcohol and Other Drug Abuse Advisory Council established under Minnesota Statutes, §254A.04, the American Indian Advisory Council established under Minnesota Statutes, §254A.035, and the Association of County Social Services Directors Rules Committee. The Department also presented the draft amendments at a series of department-sponsored training sessions for county social service agencies and chemical dependency treatment providers in Bemidji, Duluth, Willmar and Owatonna.

Over 300 copies of draft amendments were distributed and discussed at the various meetings. All comments and criticisms received were considered by the Department.

On April 23, 1990 the Department published proposed amendments to the six parts of Rule 24 (but not to part 9530.7021) and to one part of Rule 25 (part 9530.6655) in the *State Register*, Volume 14, Number 43, pages 2483-2489. Because the amendments had received so much public discussion and comment, the Department felt it was reasonable to adopt the rules without a public hearing. Accordingly, notice of intent to adopt without a public hearing was given in the April 23, 1990 *State Register*.

Comments and requests for hearing generated by the notice clustered mainly around two points: length of placement appeals (part 9530.6655) and third-party payment agreements. Commenters disagreed with how the proposed amendments treated length of placement appeals and wanted reinstated a third-party payment agreement option (new part 9530.7021) that had circulated in the draft amendments but was not included in the proposed amendments. Comments and requests related to parts 9530.6655 and 9530.7021 that were generated by the notice are included in this rulemaking record.

After consulting the Attorney General-Administration, the Department followed differing procedural routes for controversial part 9530.6655 and the six noncontroversial amendments. Part 9530.6655 as originally proposed was withdrawn, to be brought forward for public hearing along with

reinstated part 9530.7021. The other six parts have been adopted without a public hearing.

Background on parts 9530.7000 and 9530.7031

Parts 9530.7000 and 9530.7031 became effective as emergency amendments to Rule 24 at the same time that the emergency amendments to Rule 25 (parts 9530.6600 to 9530.6650) discussed below became effective. Procedurally, however, the two emergency provisions of Rule 24 were handled differently from the emergency provisions of Rule 25.

When parts 9530.7000 and 9530.7031 were published as emergency rules, they generated no controversy. Part 9530.7000 merely adds a definition of "custodial parent" that was needed to clarify the use of the term in part 9530.7031. Part 9530.7031 implements authority given the commissioner at Minnesota Statutes, §254B.041, subdivision 2 (Laws of Minnesota 1990, chapter 568, article 2, section 91) to require vendors of certain types of chemical dependency treatment services to collect fees directly from clients.

Because these parts were subject to public comment but generated no controversy and because they will be subject to more public comment in this proceeding, the Department did not convene an advisory committee to review these rule parts before bringing them to a public hearing.

As discussed below, the emergency amendments to Rule 25 *did* generate controversy and thus were reviewed by an advisory committee before being brought to a public hearing.

Background on parts 9530.6600 to 9530.6650

As discussed, some parts of the proposed permanent amendments are technical "clean-up" amendments. The majority of Rule 25's proposed permanent amendments incorporate legislatively-mandated emergency rule amendments to Minnesota Rules, parts 9530.6600 to 9530.6650. Minnesota Statutes, §254B.041, subdivision 1 (Laws of Minnesota 1990, chapter 568, article 2, section 91) required the Department to amend these rule parts by emergency rulemaking. This past summer, the Department completed the emergency rulemaking process. The emergency rules, effective August 29, 1990 and published September 10, 1990 in the *State Register*, Volume 15, Number 11, pages 627-629, are intended to decrease chemical dependency care costs and increase revenue for the counties and for the state.

During the emergency rulemaking process, comments were received from Regional Treatment Center employees, from legislators whose districts contain RTC's and from unions representing RTC employees expressing concern that the mandates of Minnesota Statutes, §254B.041, subdivision 1 to contain costs, to increase the use of outpatient treatment, to increase the use of outpatient treatment in combination with primary rehabilitation, and to limit repeated use of residential placements will adversely affect the RTC's. These letters expressed the belief that fewer clients will be placed in RTC chemical dependency programs. Because of these concerns, each group was represented on the advisory committee described in the following paragraph.

Because of the controversy generated during the emergency rule process, the proposed permanent rule amendments were developed in consultation with an advisory committee composed of representatives from counties, Regional Treatment Centers, chemical dependency programs, unions, outside experts, and the Department. The committee met once to discuss the first proposed rule draft (taken from the emergency rule). The language of the proposed permanent rule reflects input received from the committee.

SPECIFIC RULE PROVISIONS

The above-entitled rule is affirmatively presented by the Department in the following narrative in accordance with the provisions of the Minnesota Administrative Procedure Act, Minnesota Statutes, chapter 14 and the rules of the Attorney General's Office.

9530.6600 CHEMICAL DEPENDENCY CARE FOR PUBLIC ASSISTANCE RECIPIENTS; GENERAL PROVISIONS.

Subpart 2. Programs governed.

It is necessary to amend this subpart because Minnesota Rules, parts 9530.2500 to 9530.4000 were repealed in 1988 in the *State Register*, Volume 12, Number 29, pages 1451-1456; current rule parts 9530.4100 to 9530.4450 cover the same material. It is reasonable to delete the repealed language and include the correct references in order to keep the rule current.

9530.6605 DEFINITIONS.

Subpart 10a. Combination inpatient/outpatient treatment.

This new subpart is necessary in order to clarify its use in parts 9530.6630, 9530.6631 and 9530.6655. It is reasonable

because Minnesota Statutes, §254B.041, subdivision 1, paragraph (2) required the Department to adopt emergency rules establishing criteria to "increase the use of outpatient treatment in combination with primary residential treatment." Establishing combination inpatient/outpatient treatment programs is the method chosen by the Department in order to carry out this requirement. This subpart converts the emergency rule language into permanent rule language.

Subpart 12. County.

It is necessary to amend this subpart because Minnesota Statutes, §256E.08, subdivision 7 was repealed in Laws of Minnesota 1987, chapter 363, section 14; the new statutory reference is current language. It is reasonable to delete the repealed language and add the correct statutory cite in order to keep the rule current.

Subpart 15a. Facility that controls access to chemicals.

This new subpart is necessary to clarify its use in parts 9530.6625, 9530.6630 and 9530.6631. It is also necessary because members of the advisory committee agreed that without a definition, the phrase could be interpreted in many ways. It is reasonable because it assures that a client has resided or will reside in an environment free from mood-altering chemicals while in treatment and because it reflects the input of the advisory committee.

9530.6615 CHEMICAL USE ASSESSMENTS.

Subpart 3. Method of assessment.

The changes to this subpart are necessary and reasonable in order to cite the correct parts of the Code of Federal Regulations.

9530.6620 PLACEMENT INFORMATION.

Subpart 1. Level of care determination.

The changes to this subpart are necessary and reasonable for the same reasons and in the same way as noted in part 9530.6615, subpart 3.

9530.6625 PLACEMENT CRITERIA FOR OUTPATIENT TREATMENT.

Item C.

This item is necessary to comply with state law. Minnesota Statutes, §254A.03, subdivision 3 authorizes the commissioner to establish by rule criteria to be used in determining the appropriate level of chemical dependency care for clients. Minnesota Statutes, §254B.041 required the Department to establish by emergency rule ways to "contain costs," and subdivision 1, paragraph (1) specifically required the Department to establish criteria to increase the use of outpatient treatment for clients who "can abstain from mood-altering chemicals long enough to benefit" from outpatient treatment.

The emergency rule followed these requirements by adding item C, allowing a client who ordinarily would be placed in primary rehabilitation to be placed in outpatient treatment if the client will be residing in a facility that controls access to chemicals. This amendment takes the emergency rule language (while specifying that a client "will be" residing in a facility controlling access to chemicals) and converts it into permanent rule language.

It is reasonable to add item C because outpatient treatment contains costs: Outpatient treatment costs approximately $2,400 less per treatment episode than primary rehabilitation. This amendment is also reasonable because it meets the statutory requirement that outpatient treatment be increased for clients who can abstain from chemicals long enough to benefit. The major difference between outpatient treatment and inpatient treatment is that during inpatient treatment there is assurance of a chemically-free environment. However, a client in outpatient treatment living in a facility that controls access to chemicals is assured of a chemically-free environment, and therefore should be able to abstain from mood-altering chemicals long enough to benefit from outpatient treatment.

9530.6630 PLACEMENT CRITERIA FOR PRIMARY REHABILITATION OR COMBINATION INPATIENT/OUTPATIENT TREATMENT.

Subpart 1. Criteria for placement.

The amendment to subpart 1 is necessary to comply with Minnesota Statutes, §254B.041, subdivision 1, paragraph (2), which required the Department to contain costs while also increasing the use of outpatient treatment "in combination with primary residential treatment." The addition of combination inpatient/outpatient treatment is a reasonable method to carry out the intent of the legislature because it allows counties and

Indian reservations more freedom in types of placement for clients while containing costs. This amendment takes the emergency rule language and converts it into permanent rule language.

It is necessary and reasonable to delete the reference to where primary rehabilitation or combination inpatient/outpatient treatment will take place because new subpart 2 contains this language.

Item B.

It is necessary to amend item B in order to comply with Minnesota Statutes, §254A.03, subdivision 3, which authorizes the commissioner to establish criteria to be used in determining the appropriate level of chemical dependency care for clients.

Current rule language states that a client who "is unable to abstain" from chemical use while outside a facility that controls access to chemicals shall be placed in primary rehabilitation. The phrase "unable to abstain," without a reference to how long a client has been unable to abstain, has been subject to a variety of interpretations among chemical dependency assessors and has not served as a clear criterion for placement. Therefore, it is reasonable to provide clarity by delineating a precise number of days a client must be chemically free to assure consistency in application of part 9530.6630.

A client who cannot abstain from chemical use for even one week during the 30 days preceding assessment while outside a facility that controls access to chemicals is more likely to experience withdrawal or require 24-hour supervision. This client has not demonstrated an ability to abstain from chemicals in their usual environment, the community. Therefore, placement in either primary rehabilitation or combination inpatient/outpatient treatment is appropriate.

On the other hand, a client who has abstained from chemical use for at least seven consecutive days during the 30 days preceding assessment while in the community should be excluded from residential placement because the client is not likely to experience withdrawal or require 24-hour supervision and because the client has demonstrated an ability to abstain from chemicals in the community, a requirement for participation in outpatient treatment. Therefore, placement in outpatient treatment is appropriate.

Subpart 2. Type of placement.

This new subpart is necessary and reasonable because it adds back the current language of part 9530.6630, subpart 1 that refers to where primary rehabilitation will take place. Because primary rehabilitation is provided in more than one type of setting (in free standing-facilities, in hospitals, and in combination programs), it is reasonable to specify when the county has discretion to choose among these settings.

It is also reasonable to limit the county's discretion for certain clients entering combination inpatient/outpatient programs (part 9530.6631) or hospital programs (part 9530.6635) because these clients have specific experiences or characteristics which make them more likely to benefit from these programs.

This subpart takes the emergency rule language and converts it into permanent rule language, with some minor grammatical changes.

9530.6631 PLACEMENT CRITERIA FOR COMBINATION INPATIENT/OUTPATIENT TREATMENT.

This new part is necessary to comply with state law. Minnesota Statutes, §254A.03, subdivision 3 requires the commissioner to "establish by rule criteria to be used in determining the appropriate level of chemical dependency care" for clients. Minnesota Statutes, §254B.041, subdivision 1, paragraph (2) directed the Department to "increase the use of outpatient treatment in combination with primary residential treatment."

It is reasonable to require a client who has 30 consecutive days of abstinence but who meets the criteria of part 9530.6630, subpart 1 to be placed in a combination program because the client already has some of the necessary skills for maintaining sobriety. However, the client may experience problems using these skills in the community. The outpatient portion of the treatment provides the client continuing support and additional skill-building while affording the client the opportunity to "practice" in a typical environment. An inpatient placement without the outpatient portion relies entirely upon an artificial setting and does not effectively address the problem of real life application. A combination treatment program does.

This new amendment takes the emergency rule language and converts it into permanent rule language.

9530.6640 PLACEMENT CRITERIA FOR EXTENDED CARE.

Item A.

The amendment to item A is necessary to comply with Minnesota Statutes, §254B.041, subdivision 1, paragraph (3), which required the Department to establish criteria to increase the use of long-term treatment programs, i.e., extended care, for clients who are not likely to benefit from primary rehabilitation.

It is reasonable to look at previous treatment history to determine whether a client is "likely to benefit" from further primary rehabilitation because a county may discover that the client has not benefitted from several attempts at participation in various types of treatment, including primary care (Category II), extended care (Category III) and halfway homes (Category IV). If a client has not benefitted from primary rehabilitation, indicating chronic chemical use problems, it makes sense to place the client in extended care because such treatment is designed to address the client's chronic problems.

Current language of item A was meant, in part, to avoid unnecessary primary rehabilitation placements. However, the experience of counties is that sometimes a client who is most appropriate for extended care must first be placed in and then fail at primary rehabilitation in order to meet the extended care criteria. The reason a client is placed first in an inappropriate program is that the last placement may have been longer than two years ago or was a placement other than primary care. Therefore, to increase the use of extended care for a client who is not likely to benefit from primary rehabilitation, it is reasonable to look at any previous treatment history within the client's lifetime.

This amendment takes the emergency rule language and converts it into permanent rule language, with one minor grammatical addition.

9530.6641 REPEAT RESIDENTIAL PLACEMENTS.

This new part is necessary in order to comply with Minnesota Statutes, §254A.03, subdivision 3, which authorizes the commissioner to establish by rule criteria to be used in determining the appropriate level of chemical dependency care for clients. It is further necessary, and reasonable, because it is a workable method of meeting the requirements of Minnesota Statutes, §254B.041, subdivision 1, paragraph (4) to contain costs and to "limit the repeated use of residential placements for individuals who have been shown not to benefit from

residential placements, including long-term residential treatment."

There are clients who have not benefitted from extended care as it is generally provided in Minnesota. This part is reasonable because it recognizes that repeating strategies that have failed to address the needs of these clients is costly. Further, repeated placements may not be as helpful as attempting other alternatives. Therefore, this part specifically includes a requirement that an appropriate social service plan (which may include outpatient treatment) be developed and services be provided.

This part also states that if a client placed in extended care pursuant to part 9530.6640 has been there for 21 consecutive days within the past 24 months, the client cannot be placed in Category II (primary rehabilitation) or Category III (extended care). The period of 24 months is reasonable because it is based on the experience of over 2,000 clients followed up by the Comprehensive Addiction Treatment Outcome Registry (CATOR) and on the ability of the client to choose to participate. In CATOR's 1989 study entitled "Relationship of Prior Treatment History to Sobriety After Subsequent Admissions," it was found that:

> [r]ecency of previous treatment is more likely to be associated with relapse than previous treatment itself. Patients who have been admitted to treatment even as many as three times previously have very similar sobriety rates following their fourth admission to those of patients who have never been in treatment before, <u>provided that their most recent admission was at least two years ago</u>.

Twenty-one days was chosen as a measure of participation in extended care because some of the clients meeting this criteria will not have sufficiently detoxified in two weeks to be able to determine for themselves whether their needs are being addressed in extended care treatment. If clients leave during that period, it is not reasonable to conclude that they failed to benefit from the program. On the other hand, if they have participated for 21 days, it is reasonable to conclude that they had an opportunity to make an informed choice about whether continued participation was beneficial.

Except for one change, this new part takes the emergency rule language and converts it into permanent rule language. That change is using "Category II or III treatment" instead of using "primary rehabilitation or extended care treatment": both have the same meaning.

9530.6650 EXCEPTIONS TO PLACEMENT CRITERIA.

Subpart 3. Exception to extended care criteria.

It is necessary and reasonable to repeal this subpart because new part 9530.6641 makes this subpart irrelevant and unnecessary. What was optional under this subpart is now mandated by part 9530.6641.

Subpart 3a. Exceptions to part 9530.6641.

This new subpart is necessary because there are certain clients who, *under specific circumstances*, benefit from repeat residential placement or who, as a matter of public policy, deserve to be exempted from part 9530.6641. This subpart is reasonable because it is a carefully tailored exception for specific clients and because it reflects the input of public comments received following publication of the proposed emergency rules and the comments of the advisory committee.

Item A.

Item A excepts pregnant women and single custodial parents. This exception will give pregnant women and single custodial parents of minor children the opportunity to participate in residential treatment even if they have participated in extended care within the past 24 months.

The exception is reasonable because studies[1] have documented high correlations between chemical abuse in pregnant women and birth defects, and between chemical abuse and child abuse.

Further, there is evidence that single mothers are more likely to benefit from treatment than other clients. According to a 1985 report prepared by the Department's Chemical Dependency Program Division entitled "In-Patient Chemical Dependency Treatment for Women: Gender Segregated vs. Coed Programs," women who are single parents are more likely than other female clients to complete treatment, and women who are single parents who complete treatment are more likely to be abstinent six months following treatment than women who did not complete treatment.

A recent DAANES (Drug and Alcohol Abuse Normative Evaluation System - the client information system operated by the Department's Chemical Dependency Program Division) analysis of male custodial parents showed similar findings. Therefore, the exception for all custodial parents.

Item B.

A client who has specific physical or mental problems that were incorrectly (or not at all) diagnosed when last placed in treatment is also exempted from part 9530.6641 because these problems may have interfered with the client's ability to benefit from participation in the previous placement. These diagnoses may include but are not limited to brain injury, learning disability, developmental disability, a mental health diagnosis or hearing impairment.

It is reasonable to limit this exception to a client being referred to a program with services tailored to the client's special needs because the client is most likely to benefit in this environment.

Item C.

Item C exempts a client who voluntarily left a treatment program within the first week. After leaving the treatment program and upon returning to their usual environment, a client has the opportunity to reevaluate the advantages of completing treatment, and the client may return with a renewed commitment to complete treatment.

This exception is reasonable because the motivation of such a client may have improved to the point where treatment will be beneficial. It is further reasonable because it reflects the input of public comments received following publication of the proposed emergency rules and the comments of the advisory committee.

9530.6655 APPEALS.

Subpart 1. Client's right to a second assessment.

The last paragraph is deleted because the distinction drawn in the original rule language between appeal procedures for clients who are and clients who are not enrolled in a prepaid health plan no longer applies. The referenced rule part (Minnesota Rules, part 9500.1463) has been repealed. Minnesota Statutes, §256.045 governs state agency hearings as they apply to prepaid health plans under contract with the commissioner. Consequently, Minnesota Statutes, §256.045 is

the appeal route both for clients who are and clients who are not enrolled in a prepaid health plan.

Subpart 2. Client's right to appeal.

Changes proposed to this part address both form and substance. Listing as items A to E the circumstances under which a client has a right to a fair hearing is an editorial change to avoid a long awkward sentence and promote clarity. The rights listed in items A, B, and C exist in current rule. Stating that clients who are and clients who are not enrolled in prepaid health plans have the same appeal rights is added to avoid confusion that might arise because there once was a differing appeal route for these two categories of clients.

Adding disagreement with length of placement (item D) and being denied additional services (item E) as appealable issues is the substantive part of the changes proposed to subpart 2.

Item D as amended would broaden the appeal rights available to the client at that point in the process where the county indicates to the client the kind and length of service the county proposes to authorize. Specifically, the amendment adds **length** of placement to the already appealable **level** of placement. The Department's experience with the rule as written indicates the need for explicitly stating length of placement as an appealable issue. The experience occurred when an appeal on length of stay was filed and the appeals referee found no jurisdiction because length of stay was not specifically mentioned in part 9530.6655 as adopted. The Department believes that length of placement should be appealable because it is an important variable in treatment and the right of appeal protects a client from arbitrary limits being set. The Department believes it is therefore reasonable to make the changes necessary to allow an appeal on length of placement.

Item E provides an appeal right in a situation where the client agrees before treatment begins with the amount of service the local agency or prepaid health plan proposes to provide but comes to believe during treatment that the approved amount of service is inadequate. Establishing this appeal right is necessary to protect a client who identifies issues or problems during treatment that the client was unaware of when he or she signed the placement authorization plan before treatment began. It is reasonable to provide an appeal right during treatment as well as before treatment begins because it is reasonable to assume that a client might better assess his or her situation after receiving some services.

The appeal right in item E differs from the other rights established in subpart 2 because an appeal can be initiated while the client is receiving services. Specifically, the client is receiving services for which an end date has already been established in the placement authorized before the services began. The client did not exercise the length of appeal right in subpart 2, item D before beginning services. Here, the client requests additional services, the prepaid health plan or county that is financially responsible for the services denies the request, and the client appeals the denial.

Subpart 3. Services during denial of additional services appeals.

New subpart 3 is necessary to address the question of what services the client shall receive during the appeal process and to clarify the responsibilities and entitlements that do or do not apply.

The Department has considered several answers to this question. Any answer that allowed the client to continue services for "x" amount of time required a rationale for determining how long "x" should be. Allowing services to continue until the appeal was resolved was never considered a reasonable option because the appeal could take as long as 90 days to resolve; neither counties nor prepaid health plans could reasonably be expected to be financially responsible for additional services with a 90-day cap, particularly because the appeal order might find that there was no reason for the client to receive the additional services.

The Department determined that the conditions specified in subpart 3 were the most reasonable of the options considered, particularly in a time of fiscal constraint when the legislature has already mandated spending cuts related to the CCDTF.

It is reasonable that clients not be <u>entitled</u> to continue receiving services beyond the end date specified in the placement authorization because of the possibility that a county or a prepaid health plan provider could be charged for services that an appeal order found to be unnecessary. It is most reasonable to place the risk of continuing services with the provider because the provider has experience with the client and thus some basis for determining the extent to which the additional services are needed. It is similarly reasonable to hold the provider financially responsible for all services provided above and beyond the amount of service the appeal order specifies to ensure that the risk is limited to the provider and does not affect public funds. Finally, it

is reasonable, as item B provides, to protect the client from experiencing financial risk when exercising an appeal right.

The Department does not find it necessary to provide a right to appeal when the client wishes to reduce the length of treatment. The client is not compelled to continue participating in treatment unless placed under commitment by probate court. Nor is a treatment vendor compelled to keep a client in treatment for the entire period authorized by the county. Length of stay and discharge for committed clients are governed by Minnesota Statutes, chapter 253B and thus are not addressed by these rule parts.

Subpart 4. Considerations in denial of additional service appeals.

Developing factors to be considered in evaluating denial of additional service appeals is necessary to help ensure that standards governing these appeals are uniformly and consistently applied. It is reasonable to require, as item A does, that usual and customary length of placement be considered because this consideration establishes a known and accepted industry standard against which the appeal for additional services can be measured.

Considering, as item B does, whether the client has achieved stated objectives is a reasonable standard because continuing treatment for a client who has already achieved his or her placement goals is not fiscally prudent. It is similarly reasonable to assess whether the client is benefiting from the placement as stipulated in item C. Continuing a detrimental placement or one which produces no progress is not a sensible use of public funds and may prove harmful to a client. Continued placement may not be necessary if the aftercare plan which addresses a client's needs has addressed the continuing needs of the client. Hence the reasonableness of the requirement in item D.

9530.7000 DEFINITIONS.

Subpart 9a. Custodial parent.

This new subpart is necessary in order to clarify its use in part 9530.7031, item A. That part provides that a vendor of Category III (extended care) or Category IV (halfway house) residential rehabilitation services shall determine the client's fee, but only for a client "who has no responsible relative and who is not the *custodial parent* of a minor child." (emphasis added)

It is reasonable to define "custodial parent" because if the client _is_ a custodial parent, part 9530.7031 does not apply. Instead, the fee is based on the CCDTF's sliding fee schedule, found in part 9530.7020, subpart 3. Only a client who is not a custodial parent of a minor child must pay the fee determined by the vendor.

9530.7021 PAYMENT AGREEMENTS.

This provision has the effect of allowing treatment vendors to be paid directly by an insurer or HMO rather than through the CCDTF when a CCDTF-eligible client is also eligible for insurance or HMO coverage. It is necessary for the Department to allow and facilitate the direct payment option for reasons related to cost containment and prudent management of public funds.

Adding the option of a payment agreement is particularly necessary because lack of such a provision would likely result in increased treatment rates being charged to the CCDTF. This is the case because rates to be paid by the CCDTF are negotiated by the county in which the provider is located. Many providers negotiate discounted rates for CCDTF clients. Clients who have third-party insurance coverage which requires a sizable copayment are frequently also eligible for CCDTF funding because they cannot afford to make the copayment. In these cases, the treatment provider must accept the discounted rate set in the county agreement. Often the amount the insurer would have paid, even without the copayment, would have been greater.

In meetings to gather input for these rules, treatment providers informed the Department that the CCDTF eligibility of insured clients had not been considered in negotiating rates with the counties. If the higher insurance payments cannot be collected by the treatment providers they will need to increase their negotiated rates. This increase would increase costs to the CCDTF.

Allowing vendors to bill third-party payors directly is also necessary to avoid tying up CCDTF funds allocated to the counties. Under current practice, the Department pays the vendor and then bills the insurer or HMO responsible for a portion of the CCDTF-eligible client's treatment cost. The Department credits the CCDTF allocation of the responsible county when the third-party payment is received. But the allocation is reduced by the amount the third-party payor owes between the time the fund makes payment and the time the payment is received from the third party. Because it routinely takes several months for third-party payors to pay, the county may have to deny service to a client who would be

eligible if the county allocation were not tied up awaiting the third-party payment. The agreement specified is a reasonable way to ensure that both the vendor and the client understand and agree to the method of payment and the limit of the client's obligation. The county's participation assures that placement is appropriate to the client's needs and that the client's obligation is determined according to rule.

It is necessary for the vendor to notify the county before discharging a client for lack of funding because the fact that the client is eligible for public assistance to pay for services means that the county is responsible for the client. Some decisions to end funding made by third-party payors are arbitrary and not necessarily in the best interest of the client. It is necessary to give the county an opportunity to evaluate the client's progress and determine whether the placement should continue using public funds.

It is reasonable that this notice be provided as soon as possible before the client is discharged because it gives the county time to make its determination. While one day requires the local agency to respond quickly, a longer period may place a financial burden on the vendor. The third-party payor sometimes provides the vendor with only one day notice.

9530.7031 VENDOR'S DUTY TO COLLECT CLIENT FEES.

It is necessary to require vendors to collect client fees in order to comply with Minnesota Statutes, §254B.041, subdivision 2.

In collecting client fees as authorized in Minnesota Statutes, §254B.06, the Department has found that a client is more likely to pay a fee when the client receives the bill close to the time of discharge. The longer the time between the client's receiving treatment and the client's receiving a bill, the harder it is to collect. In the case of extended care and halfway house clients, the fee is usually determined at the end of a month of service. This information is put on the invoice and sent to the county for verification. The county sends the invoice to the Department, and the Department then generates a bill to the client. By the time the client receives the bill, nearly two months have gone by since the services for which the client is being billed began. The time is two months only if there have been no delays at the treatment facility, the county level, or the Department.

After two months, the client may have spent the income which was determined to be available for payment of the fee. Some clients will have left the facility. Clients who require extended care (Category III) or halfway house (Category IV) services are the clients who have had the most disruption in their lives due to chemical use. They are not likely to be returning to a permanent address and are difficult to locate after leaving treatment.

The Department estimates that $328,269 in fees owed by halfway house clients goes uncollected each year.

It is reasonable to specify the responsibilities of the vendor in rule so that the vendor and the county can know what is expected of the vendor and when those expectations have been met.

Item A.

It is necessary to determine the client's fee according to part 9530.7024 so that the fee for governed clients is determined in a uniform manner.

It is reasonable that the vendor determine the fee because the vendor has immediate access to the client and the information necessary for the determination.

Item B.

It is necessary that the vendor collect the fee from the client because increased vendor fee collection is mandated in Minnesota Statutes, §254B.041, subdivision 2. It is reasonable for the vendor to provide a client with receipts because receipts avoid future disputes. The receipts will provide documentation that the client met his or her obligation to pay fees and that vendors have met their obligation to determine and collect fees.

Item C.

It is necessary to govern discharge of a client for nonpayment of fees in order to assure that discharge is applied fairly to all clients in a specific program. It is reasonable to leave the decision of whether to discharge a client for non-payment to the vendor because the focus of the program differs among vendors. Some vendors provide programs which focus on developing responsibility for financial obligations and obtaining employment. These vendors may choose to discharge clients who do not pay fees. Other vendors provide programs which focus on the resolution of problems which frequently accompany chemical dependency such as eating disorders, depression, victimization, or lack of parenting skills. These

vendors may choose not to discharge a client for non-payment of fees, feeling that progress in other areas is more important.

The determination of whether or not to discharge for non-payment of fees is thus properly left with the vendor as long as the vendor applies the discharge criteria uniformly throughout a program.

It is necessary to exclude committed clients from this provision because the discharge of committed clients is specifically governed by Minnesota Statutes, §253B.16. It is reasonable to include the information about commitment to avoid confusion on the part of counties and vendors and assure compliance with the statute.

Item D.

It is necessary to require vendors to remit client fees and identifying information to the Department so that it has accurate information with which to audit vendors and to bill clients for collections the vendor was unable to make. It is reasonable to require the vendors to use a form specified by the Department so that the information supplied by the vendors is uniform. This uniformity will facilitate accurate and timely processing of the information at the department.

Item E.

It is necessary for the Department to pay a vendor for client fee collections because the vendor has been given a part of the Department's responsibility to collect client fees. It is reasonable to pay the vendor five percent of the client fees collected because that amount is specified in Minnesota Statutes, §254B.041, subdivision 2. It is reasonable to allow flexibility in the time frame for paying the vendor because more frequent distribution of payments to vendors may result in the Department issuing very small checks frequently to the same vendor. Quarterly payments could result in reducing the number of checks issued by one-third without having a significant impact on vendor cash flow.

Items F and G.

It is necessary to specify when the vendor's obligation to collect ends and the Department's begins to avoid both parties billing the client for the same fee obligation.

It is reasonable for the vendor's obligation to end at the time of discharge because at that time the vendor usually loses contact with the client and no longer is in an advantageous position to collect the fee.

It is reasonable for the Department to assume the responsibility of collecting fees the vendor was unable to collect because the Department has greater resources for locating clients and seeking judgments against future income or tax refunds.

It is reasonable for the Department to base its collections efforts on information supplied by the vendor because the vendor will have determined the client's fee obligations according to item A and will have provided payment information to the Department according to item D.

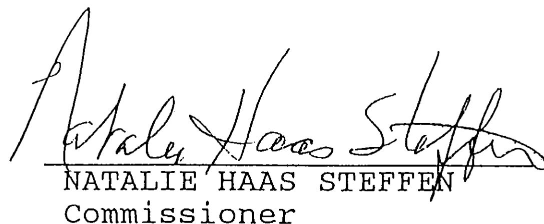
EXPERT WITNESSES/SMALL BUSINESS

If this rule is heard in public hearing, the Department does not intend to have outside expert witnesses testify on its behalf. The proposed rule amendments do not affect small businesses as defined in Minnesota Statutes, §14.115.

AGRICULTURAL LAND

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

Dated: March 27, 1991



NATALIE HAAS STEFFEN
Commissioner

NOTES

[1] Julianne Conry, "Neuropsychological Deficits in Fetal Alcohol Syndrome and Fetal Alcohol Effects," Alcoholism: Clinical and Experimental Research, Vol. 14, No. 5, September/October 1990, pp. 650-55; Richard Famularo, M.D., Karen Stone, Ph.D., Richard Barnum, M.D., & Robert Wharton, M.D., "Alcoholism and Severe Child Maltreatment," American Journal Orthopsychiatric Assn. Inc., (July 1986), pp. 481-85; Dianne Hoshall Colemen and Murray Straus, "Alcohol Abuse and Family Violence," Alcohol, Drug Abuse and Aggression, (Family Violence Research Program, 1983), pp. 104-24; Judianne Densen-Gerber, "The Forensic Pathology of Drug-Related Child Abuse," Legal Medicine Annual, 1978, pp. 135-47; and M. Virkkunen, M.D., "Incest Offences and Alcoholism," Medicine, Science, and the Law, (April 1974), pp. 124-28.

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* all works cited are available from the Minnesota Department of Human Services, Rules Division, 444 Lafayette Road, Saint Paul, MN 55155-3816