STATE OF MINNESOTA
DEPARTMENT OF HUMAN SERVICES

IN THE MATTER OF THE PROPOSED AMENDMENTS OF DEPARTMENT OF HUMAN SERVICES RULES RELATED TO MENTAL HEALTH SERVICES UNDER MEDICAL ASSISTANCE, MINNESOTA RULES, PART 9505.0323, SUBPART 4, ITEM I, SUBITEM (5)

STATEMENT OF NEED AND REASONABLENESS

Introduction

Minnesota Rules, part 9505.0323 establishes the standards and procedures for mental health services to medical assistance recipients. The amendments to Minnesota Rules, part 9505.0323, subpart 4, item I, subitem (5) are proposed by the Department of Human Services (hereafter, the Department) to revise the standards for referral of a medical assistance recipient by a mental health professional who is conducting the recipient's diagnostic assessment to a psychiatrist for a psychiatric consultation or medication evaluation.

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

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

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

Minnesota Rules, part 9505.0323, establishing eligibility to receive medical assistance payment as a provider of mental health services, became effective January 1, 1990. The standards set forth at that time were those then in effect under the Minnesota comprehensive adult mental health act found in Minnesota Statutes, sections 245.461 to 245.486 and under the Medical Assistance Program found in Minnesota Statutes, Chapter 256B as well as Title 42, Code of Federal Regulations. Subsequently, the Department proposed and, subsequent to a public hearing, adopted amendments to part 9505.0323. Some of

these amendments were for the purpose of assuring consistency with the Minnesota comprehensive children's mental health act, Minnesota Statutes, sections 245.487 to 245.4888 and amendments to the Minnesota comprehensive adult mental health act and others were for purposes of clarification or enhanced recipient services through procedures that would lead to early identification and intervention. The amendments became effective December 21, 1992.

Action of the Legislative Commission to Review Administrative Rules

On January 6, 1993, in response to complaints received from Mr. William Conley, Mental Health Association, (hereafter, MHA) and Dr. Seymour Gross, Minnesota Psychological Association, (hereafter, MPA), the Legislative Commission to Review Administrative Rules, (hereafter, the LCRAR), held a preliminary assessment of whether the Department had established the necessity and reasonableness of part 9505.0323, subpart 4, item I, subitem (5). Pursuant to Minnesota Statutes, section 3.843, the LCRAR adopted a motion directing the Department to proceed to a rulemaking hearing under Minnesota Statutes, sections 14.05 to 14.36 on this provision within 90 days, or by April 6, 1993. The LCRAR further directed the Department to amend subitem (5) to give special consideration to the alternative language proposed by MHA and MPA. Finally, the LCRAR encouraged the Department "to bring the parties together to agree on some compromise language to address their concerns....". See Attachments 1 and 2.

Rule development procedures

A Notice of Solicitation of Outside Information or Opinions was published in the State Register on January 19, 1993 at 17 S.R.1799.

Mental health professionals who provide mental health services under the medical assistance program pursuant to part 9505.0323 come from several disciplines. They are registered nurses who are clinical specialists in psychiatric and mental health nursing, licensed independent clinical social workers, psychologists, and psychiatrists. See part 9505.0175, subpart 28. The Department therefore invited a representative cross section of these disciplines to participate in assisting the Department to develop "compromise language to address [MHA and MPA] concerns which have now become the concerns of the LCRAR." See Attachment 1. The Department also invited representatives of advocacy organizations such as the Office of the Ombudsman for Mental Health and Mental Retardation and the Mental Health Law Project, physician groups such as the Minnesota Academy of Family Physicians, and community mental health centers. The list of persons contacted is in Attachment 3.

The Advisory Committee met on January 25 and January 28, 1993. Attachment 3 lists the persons who attended those meetings.

The proposed amendments to part 9505.0323, subpart 4, item I, subitem (5) reflect the compromise language agreed to by persons attending the January 28 meeting of the advisory committee.

The Department believes that the proposed amendments also reflect the written comments received from mental health professionals who were unable to attend the two meetings of the advisory committee.

Small business concerns

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

Part 9505.0323, subpart 4, item I, subitem (5)

Members of the community of mental health professionals and mental health advocates have testified to the LCRAR, commented during meetings of the Advisory Committee, or written to the Department that the mandatory referral of medical assistance recipients who are receiving a diagnostic assessment of their mental illness or emotional disturbance and who have never been referred to psychiatrist or a physician for a psychiatric consultation or medication evaluation will be burdensome both to recipients and to psychiatrists. Some expressed the opinion that the required referral seems to reflect a Department bias toward medication and psychiatric interventions that may be contrary to good practice. Others were concerned that a recipient's perception of the stigma attached to referral to a psychiatrist would serve as a barrier to the recipient receiving psychologically-oriented mental health services that were necessary and appropriate to treat the recipient's mental illness or emotional disturbance. Several physician members of the advisory committee stated that, if the Department's intent was to assure the recipient a medical evaluation as well as a psychiatric consultation and medication evaluation, the present rule should be amended to require the recipient's referral to both a physician and a psychiatrist. One physician expressed the opinion that the present mandated referral could be implemented under a managed care contract but not in the fee-for-service environment used by many medical assistance recipients. He also argued that, because the required evaluation is not central to the intervention that triggered the referral, the evaluation will most likely be done by someone not regularly associated with the referring mental health professional and probably will be performed in a perfunctory, untimely manner. Thus, the findings of the evaluation may be of little or no value to the mental health professional providing the recipient's mental health services.

On the other hand, support for retaining the present mandatory referral requirement came from the Minnesota Academy of Family Physicians and the representative of the Minnesota Association of County Social Service Administrators.

After considering all viewpoints, the Department proposes to amend subitem (5) to limit the circumstances in which a referral will be mandatory. The circumstances requiring a mandatory referral are those suggested by MPA, MHA,

and members of the Advisory Committee. Furthermore at the meeting of January 28, 1993 members of the Advisory Committee agreed to the concepts in the proposed amendment.

A diagnostic assessment is used to determine whether a person has a mental illness or an emotional disturbance. It also identifies the mental health services that are medically necessary for the recipient as a result of the recipient's mental illness or emotional disturbance. The proposed amendment limits the referral requirement to those recipients who have not had a psychiatric consultation or medication evaluation and who have certain specific diagnoses. According to members of the Advisory Committee, there are certain mental illnesses and emotional disturbances for which medication may be a necessary and appropriate treatment. If the mental health professional diagnoses the recipient as having one of these illnesses or disturbances and if the scope of licensed practice of the mental health professional does not include the prescription and evaluation of the effectiveness of medication, it is necessary that the mental health professional refer the recipient to the mental health professional with the appropriate license. Because a psychiatrist is the mental health professional whose scope of practice includes medication evaluation and who has knowledge and experience in the treatment of mental illness and emotional disturbance, it is reasonable to require the referral to be to a psychiatrist. The psychiatrist is qualified to determine whether medication is necessary and to prescribe the appropriate medication and dosage.

Subpart 2 of part 9505.0323 requires the diagnostic assessment of a recipient who is receiving mental health services under medical assistance to be reviewed and updated once every 12 months or requires a new diagnostic assessment if there is a marked change in the recipient's mental health condition. If such a change occurs, the services specified in the recipient's previous diagnostic assessment may no longer be medically necessary or appropriate for the recipient. Thus it is necessary to specify a time limit to assure that the recipient's referral to a psychiatrist occurs in a timely manner that does not unduly burden the recipient, is related to the recipient's current mental status, affords the recipient the opportunity to receive a potentially beneficial service, and provides the mental health professional who is not a psychiatrist information about service needs outside of his or her scope of licensed practice.

Limiting the required referral to those recipients who have not had a psychiatric consultation or medication evaluation within the preceding 180 days is consistent with the requirement for adults found in Minnesota Statutes, sections 245.467, subdivision 2 and for children in section 245.4876, subdivision 2. These statutes state that a new diagnostic assessment is not required if one is available and has been completed within the preceding 180 days and the recipient's condition has not changed markedly.

The diagnoses of schizophrenia, bipolar disorder, major depression, or borderline personality disorder for which the adult's referral is required are those found in the definition of serious and persistent mental illness in Minnesota Statutes, section 245.462, subdivision 20, paragraph (c), clause (3)(i). The diagnoses of psychosis or clinical depression or risk of harming

self or others as a result of emotional disturbance for which a child's referral is required are those found in the definition of severe emotional disturbance in Minnesota Statutes, section 245.4871, subdivision 6, clause (3)(i) and (3)(ii). The MPA, MHA, and members of the Advisory Committee advised the Department that limiting the referrals to this population is reasonable because the limit is consistent with the Comprehensive Mental Health Act, will reduce the number of required referrals to a size more consistent with the number of psychiatrists available in Minnesota and thus make access to psychiatric services more readily available to those most in need, will reduce the likelihood of unnecessary referrals for psychiatric services, will reduce the potential fiscal impact under the present rule's mandatory referral requirement, and will enhance interdisciplinary consultation for persons with complex and severe mental illnesses and disorders and for persons at risk of harm to themselves or others.

Correspondence received from the MPA before the first Advisory Committee meeting stated that a meeting of representatives of MPA and child psychiatrists resulted in a recommendation of the psychiatrists to add a diagnosis of mood disorder or obsessive compulsive disorder to the language MPA recommended to the Department about the referral of children with severe emotional disturbance. The Advisory Committee agreed with this recommendation. Additionally, a child psychiatrist member of the committee recommended that the diagnoses of attention deficit hyperactivity disorder (ADHD) and undifferentiated attention deficit disorder (ADD) should also result in a referral to a psychiatrist or a physician. He stated that many children with severe emotional disturbance who are under the jurisdiction of the corrections system and are in residential treatment would not be there if they had been referred to a psychiatrist at an early age for psychiatric consultation and medication evaluation. The Advisory Committee accepted his recommendation. Finally the committee agreed that the referral of a child with ADHD or ADD should be to either a psychiatrist or a physician as this provision is consistent with physician licensure and the current standard of medical practice and recognizes that physicians who are not psychiatrists customarily treat such children.

Requiring the mental health professional conducting the recipient's diagnostic assessment to specify in the recipient's record the consideration of biological factors which may be contributing to the recipient's mental illness or emotional disturbance and also the reason if the referral is not made is reasonable as the record is evidence of compliance with the requirement. Additionally, members of the Advisory Committee recommended that the rule be amended to require a non-physician mental health professional to document the consideration of biological factors as a means to assure appropriate referrals.

The Department notes that, in addition to making the mandatory referral required under this subitem, a mental health professional may refer a recipient for medically necessary services that are outside the professional's scope of practice at any time. See part 9505.0323, subpart 4, item I, subitem (6).

The Department further notes that the mandatory referral will not delay the

initiation of mental health services provided by the non-physician mental health professional. The mental health professional conducting the diagnostic assessment may initiate treatment and bill medical assistance for the diagnostic assessment and other mental health services before receiving the report of the psychiatrist or physician to whom the recipient was referred. The recipient will have the freedom of choice required under 42 CFR 431.51 and part 9505.0190, including the right to decline a referral. The intent of the rule is not to restrict the recipient's access to mental health services but rather by encouraging prompt referral to assure coordination of the recipient's services and thereby enhance the quality of the recipient's care. Additionally, the Department believes that such timely, coordinated treatment may achieve cost savings from reduced use of inpatient hospitalizations and residential treatments. The reduction in the use of inpatient hospitalization and residential treatment would occur through enhancing the recipient's ability to benefit from the mental health services provided by the non-physician mental health professionals through a potentially earlier psychiatric consultation and medication evaluation by the physician or psychiatrist. Members of the Advisory Committee commented that some persons with the diagnoses for which referral is required are unable to benefit from psychotherapy unless they are receiving effectively prescribed medication. The combined effect of medications and psychotherapy for these recipients leads to efficient use of medical assistance services and dollars as required under Minnesota Statutes, section 256B.04, subdivision 2.

The proposed amendment deletes the rule provision which limits payment for ongoing medication monitoring and evaluation to a psychiatrist for certain diagnoses. The Department has carefully reviewed the medical assistance rules, parts 9505.0175 to 9505.0475, paying special attention to part 9505.0323 establishing standards for medical assistance payment for mental health services and part 9505.0345, related to physician services. The Department's review failed to find support for limiting payment for these services to those provided by a psychiatrist. The scope of licensed practice of a physician includes the prescription and evaluation of the effectiveness of medications. Members of the Advisory Committee who are physicians and psychiatrists agreed that placing such a limitation on these services makes it seem as if the rule is attempting to define a physician's scope of practice. The representative of the Minnesota Academy of Family Physicians stated that family physicians are trained to function as first line primary care physicians and are competent to address mental health issues and consider the need for psychotropic medication. He further stated that family physicians work closely with specialists in psychology and psychiatry but that they are often called upon to make the initial assessment and start a patient on a medication regimen that will stabilize their mental health status until such time as a referral to a psychiatrist or psychologist can be arranged. Therefore, the Department believes it is reasonable to delete this payment limitation in order to encourage the timely initiation of medication necessary to stabilize the condition of those patients who require medication but do not have immediate access to the services of a psychiatrist.

Expert witnesses

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

Dated: 2-4-93

NATALIE HAAS STEFFEN
Commissioner of Human Services

LCRAR

Legislative Commission

to Review Administrative Rules

Representative Peter Rodosovich
Chair

Senator Phil Riveness
Vice Chair

55 State Office Building
St. Paul, Minnesota 55155-1201
Telephone 612/296-1143

Maryanne V. Hruby, Director

January 6, 1993

Preliminary Assessment: **Department of Human Services, Minnesota Rules, part 9505.0323, subpart 4, item I, paragraph (5)**

Mandatory Referral to Psychiatrist or Other Physician for Psychiatric Consultation or Medication Evaluation

The Complaint

This issue comes to the Commission at the request of **Senator Hottinger** on behalf of the Minnesota Psychological Association (MPA). It concerns a newly adopted permanent rule of the Department of Human Services (DHS) that requires mental health professionals to refer to a psychiatrist or other physician all Medical Assistance recipients who have never had a psychiatric consultation or medication evaluation. DHS imposed the referral requirement to ensure that all MA recipients undergo an evaluation of biological factors which may be contributing to the recipient's mental illness or emotional disturbance.

The Rulemaking Process

As originally proposed in the *State Register* on July 13th (see attached), the rules amended subpart 4, item I, paragraph (6) by deleting the requirement that a mental health professional must refer a recipient for "medically necessary services that are outside the scope of practice of the mental health professional" and replacing it with a requirement that mental health professionals must refer the recipient for a psychiatric consultation and medication evaluation, if the recipient has not had one or if the mental health professional believes an updated consultation or re-evaluation for medication is necessary. DHS has very broad rulemaking authority (see attached, M.S. section 245.484) for its mental health services rules, and more specific authority (see attached, M.S. section 256B.04, subdivision 2) for its Medical Assistance rules.

A rulemaking hearing was held on August 13, 1992. An MPA representative testified in opposition to the proposed rule. The MPA also submitted comments to the Administrative Law Judge during the post-hearing comment period.

After the hearing, DHS modified the rule to amend paragraph (5) (see attached, adopted rule in *State Register*, December 14, 1992) by requiring referral in all cases where a recipient has never had a psychiatric consultation or medication evaluation, regardless of whether the mental health professional believes a consultation or evaluation is necessary. DHS then reinstated the scope of practice language in paragraph (6).

On October 9, 1992, the Administrative Law Judge issued his rule hearing report. He accepted the modified rule language, summarily deemed that it was not a substantial change to the rules as initially proposed, and found the rule to be needed and reasonable.

In late October, LCRAR staff met with DHS staff on behalf of the complainants. In mid-November, DHS held a meeting attended by psychologists, child psychiatrists, and LCRAR staff. DHS has held firm to the language in the

rule and has chosen not to modify or withdraw the rule. The department published the rules as adopted in the *State Register* on December 14th. The rules are currently in effect.

Complainants' Position

The MPA and the Mental Health Association of Minnesota (MHAM) remain concerned about the new rule:

- They do not believe the department has satisfactorily justified the mandatory referral requirement.
- They fear it will burden both recipients and psychiatrists, and will divert recipients from further necessary mental health care.
- They question the need for change in view of rules and professional codes that already require referrals for medically necessary services that are outside the scope of practice of mental health professionals.
- They believe it is inappropriate in some cases for DHS to encourage the use of drug therapy.
- They do not believe the new requirement is cost-effective.
- They are disturbed that this controversial issue was not discussed at the rule advisory committee before publication in the *State Register* and that the Administrative Law Judge did not discuss the issue at any length in his hearing report.
- They believe the rule is unworkable, unnecessary, ill-advised and want it nullified. They have prepared alternative rule language to address their concerns (see attached letters from MPA to DHS, 12/31/92, and from MHAM to DHS, 11/11/92).

Department's Position

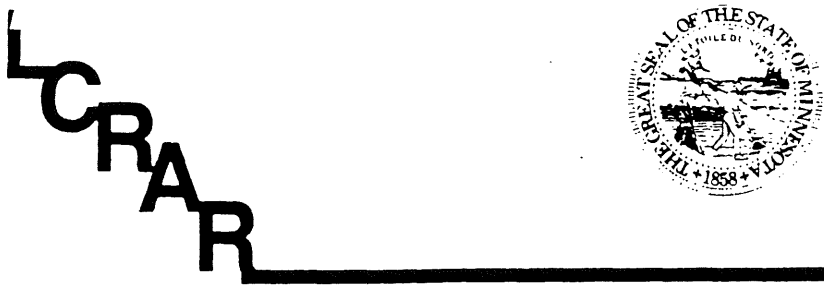
The department believes the rule change is necessary to ensure that Medical Assistance (MA) monies are spent wisely and to ensure that MA patients receive necessary physical medical care when they also seek mental health services. DHS is also concerned about the adequacy of education of some mental health professionals. While the department uses task forces to develop rules, policy staff stress that these task forces are only advisory, and that opponents to the rules had an opportunity to object at the rulemaking hearing. DHS also believes that the final adopted rule is less burdensome than the rule as originally proposed.

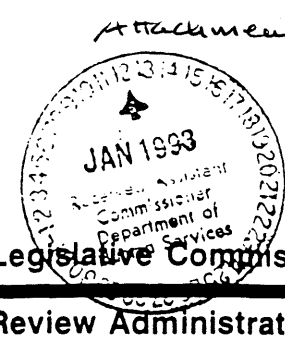
LCRAR Role

The purpose of a preliminary assessment is to present a rule complaint to the Commission. At a preliminary assessment, the Commission generally takes sufficient testimony to understand the issues and to enable it to determine if the complaint is meritorious and worthy of its attention. If the Commission agrees to proceed with its review of the rule in question, it has several options:

1. The Commission may hold a subsequent public hearing on the issue, if it feels it has not received sufficient testimony today.
2. The Commission may direct DHS to hold a rulemaking hearing, according to M.S. section 3.843, within 60 days or any longer period as specified by the Commission.
3. The Commission may refer the issue to the appropriate policy committees, alerting them to the need for legislation to resolve the problems the Commission is concerned about.
4. Members may sponsor legislation to address the issue.
5. The Commission may initiate suspension of the adopted rule. This means it would hold a formal public hearing to take further testimony, after which it would refer the issue of rule suspension to the appropriate policy committees for 60 days or until the policy committees advised the Commission on whether to suspend the rule. The Commission then would hold a third meeting on the issue to decide whether to suspend the rule. Six affirmative votes are required to suspend a rule.
6. The Commission may take no action at this time.

Attachment 2





Legislative Commission
to Review Administrative Rules
55 State Office Building
St. Paul, Minnesota 55155-1201
Telephone 612/296-1143

Maryanne V. Hruby, Director

Representative Peter Rodosovich
Chair

Senator Phil Riveness
Vice Chair

January 11, 1993

Helen Yates, Assistant Commissioner
Department of Human Services
444 Lafayette Road
St. Paul, Minnesota 55155

Dear Assistant Commissioner Yates:

Pursuant to our authority in Minnesota Statutes, Section 3.843, and according to the motion approved at our meeting on January 6th, the LCRAR expects the Department of Human Services to proceed to a rulemaking hearing under sections 14.05 to 14.36 within 90 days, or by April 6, 1993. The subject of the rulemaking hearing is the Commission's recommendation that Minnesota Rules, part 9505.0323, subpart 4, item I, subitem 3, paragraph (5) be amended to accommodate the alternative language offered by the Minnesota Psychological Association and the Minnesota Mental Health Association. I encourage the department to bring the parties together to agree on some compromise language to address their concerns, which now have become the concerns of the LCRAR. If you need assistance to meet our direction, please contact LCRAR staff as soon as possible.

Thank you for your attendance at our meeting and for your attention to this matter.

Sincerely,

Representative Peter Rodosovich
Chair, LCRAR

cc: Senator Riveness, Vice-Chair, LCRAR

MENTAL HEALTH SERVICES UNDER MEDICAL ASSISTANCE
Part 9505.0323, subpart 4, item I, subitem (5)
PERSONS CONTACTED TO ATTEND ADVISORY COMMITTEE MEETINGS

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MENTAL HEALTH SERVICES UNDER MEDICAL ASSISTANCE

PART 9505.0323, subpart 4, item I, subitem (5)

ADVISORY COMMITTEE MEMBERS PRESENT JANUARY 25, 1993

Ms. Virgina Barzan, Minnesota Acadaemy of Family Physicians

Mr. Ron Brand, Minnesota Association of Mental Health Programs

Rebecca Buller, Minnesota Psychological Association

Mr. Eugene Burke, Upper Midwest Association for Marriage and Family Therapy

William Conley, Mental Health Association

Ms. Anne Gearity, National Association of Social Workers

Dr. Seymour Gross, Minnesota Psychological Association

Dr. Kenneth Kephart, Minnesota Academy of Family Physicians

Ms. Gretchen Musicant, Minnesota Nurses Association

Mr. Tim Olson, Minnesota Association of County Social Service Administrators

Dr. George Realmuto, Child Psychiatry, University of Minnesota

John B. Waldron, Ombudsman for Mental Health and Mental Retardation

Ms. Denise Wilder, Minnesota Women Psychologists

Observer: Marjorie Duske, Legislative Commission to Review Administrative Rules

MENTAL HEALTH SERVICES UNDER MEDICAL ASSISTANCE

PART 9505.0323, subpart 4, item I, subitem (5)

ADVISORY COMMITTEE MEMBERS PRESENT JANUARY 28, 1993

Mr. Ron Brand, Minnesota Association of Community Mental Health Programs

Mr. Eugene Burke, Upper Midwest Association for Marriage and Family Therapy

Ms. Rebecca Buller, Minnesota Psychological Association

Mr. William Conley, Mental Health Association

Phillip Edwardson, M.D., Minnesota Society for Child and Adolescent Psychiatry

William Erickson, M.D., Department of Human Services

Ms. Flossie Finnicum. Hennepin County Medical Center

Dr. Seymour Gross, Minnesota Psychological Association

Mr. Tom Keliher, Minnesota Psychological Association

Ms. Susan Lentz, Minnesota Psychologists in Private Practice

Ms. Gretchen Musicant, Minnesota Nurses Association

Mr. Tim Olson, Minnesota Association of County Social Service Administrators

Mr. Bill Strusinski, Minnesota Psychological Association

Ms. Suzanne Veenhuis, Minnesota Medical Association

Mr. Charles Westin, Minnesota Licensed Psychologists

Ms. Denise Wilder, Minnesota Women Psychologists

Rebecca Zuckweiler, Nurses in Private Practice