

Minnesota Attorney General: Administrative Rules Proceedings

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Version 3
August 20, 2018

Our File # 552

RULES REVIEW CHECKLIST

DATE RULES RECEIVED 10-18-79 Temporary Rule _____

Resubmitted and Received 11-29-79
Lee 10/26

DUE DATE 11-7-79 12-9-79

a. Returned to Agency w/o filing w/Secy of State 11-5
b. Approved 11/30 Date Sent Back to Agency _____

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Our File: # 552

DEPARTMENT: Attorney General

STATE OF MINNESOTA

Office Memorandum

TO : George R. Pettersen, MMD
Commissioner of Health
Department of Health

DATE: November 30, 1979

FROM : Lee E. Sheehy
Special Assistant
Attorney General

PHONE: 296-1238

SUBJECT: Rules as Approved ~~In~~ the Matter of the Rules of the Minnesota Department of Health Relating to theServices to Children with Handicaps and Adults With Cystic Fibrosis and Hemophilia For Eligibility, Cost-Sharing and Reimbursement.

Enclosed herewith are the rules you have submitted for approval. These rules have been approved by this office and filed with the Secretary of State. Note that they have NOT been filed with the State Register; this must be done promptly by your agency.

Upon receipt and before transmittal to your agency, however, it is important that you recheck these rules as to:

1. Affixation of the stamps of the Attorney General and Secretary of State to the last page of the rules;

2. Coverage by these stamps of all rules submitted; and

3. Inclusion of all pages of the rules in the approved set.

Directly following the approved rules is a complete set of required documents and transcript which must be retained with the rules by you or your agency.

If you have any questions in this regard, please contact me.

LES/dw
Enclosure
cc: Marshall Whitlock
Duane Harves

FINAL RULE

SERVICES FOR CHILDREN WITH HANDICAPS

DEPARTMENT OF HEALTH

RULES OF THE MINNESOTA DEPARTMENT OF HEALTH
RELATING TO ~~THE-CRIPPLED-CHILDREN-SERVICES~~
THE SERVICES FOR CHILDREN WITH HANDICAPS and
ADULTS WITH CYSTIC FIBROSIS AND HEMOPHILIA
FOR ELIGIBILITY, COST-SHARING AND REIMBURSEMENT

CHAPTER THIRTY-ONE: 7 MCAR §§ 1.651 - 1.657

7 MCAR § 1.651 General

A. Declaration of Purpose, Scope and Applicability

These rules apply to the parent(s) or guardian(s) of handicapped and potentially handicapped children under the age of 21, self-supporting handicapped and potentially handicapped individuals under 21 years of age, individuals 21 years of age or over with cystic fibrosis or hemophilia, and those health professionals and institutions that provide services to eligible individuals with handicaps. The Federal Act (Title V, USC 42, Chapter 7) authorizing ~~Crippled-Children-Services-(CCS)~~ Services for Children with Handicaps (SCH) provides annual formula funds to the state, which are augmented by state appropriation; therefore, reimbursement to providers under these rules is subject to the limitation of these funds and the funds appropriated under Minnesota ~~Laws-1977,-Chapter-453,-Section-24,~~ law.

The purpose and scope of these rules is to specify the ~~Crippled-Children-Services-(CCS)~~ Services for Children with Handicaps (SCH) criteria, procedures and responsibilities relating to applicant eligibility, applicant cost-sharing and reimbursement to service providers for service(s) authorized by CCS SCH for physically handicapping conditions in children.

B. Definitions

For the purposes of these rules, the following terms shall have the meaning given them:

1. "Adjusted gross income" means all of the income received by the applicant, less the deductions allowed by the IRS for business and professional expenses as declared on the most recent IRS statement of federal adjusted gross income for the immediately preceding tax year.

2. "Administrative Review Committee" means the committee, as identified by the Commissioner of Health, composed of administrative personnel from the Division of Personal Health Services and the ~~GGS~~ SCH Program and a representative from the ~~GGS~~ SCH field staff who have responsibility for the review of ~~GGS~~ SCH decisions relating to eligibility and cost-sharing for those applicants who wish such reconsideration.

3. "Allowable deductions" means those expenses incurred by household members for the following items:

   a. Medical-dental expenses for treatment and other health care related expenses paid during the previous twelve months which were not reimbursed by a third-party payer such as insurance or Title XIX (Medical Assistance).

   b. Transportation costs in order to obtain medical/dental care and services during the previous twelve months.

      1) Travel expenses by car are calculated at ~~$.10~~ $.17 a mile.

      2) Actual costs of train, airplane, bus and taxi fares.

4. "Applicant" means the individual who requests the services offered by ~~CCS~~ SCH or the parent(s) or legal guardian(s) of such an individual.

5. "Application" means a written request for service and/or cost-sharing determination signed by the applicant on forms specified by ~~CCS~~ SCH.

6. "Authorization form" means the document designed and supplied by ~~CCS~~ SCH to the service provider with a copy to the applicant, outlining the service(s) requested for the individual and the conditions of payment by ~~CCS~~ SCH to the service provider.

7. "Child with a handicap" means an individual under 21 years of age who has a disease or physiological condition which might hinder the achievement of normal growth and development.

8. ~~"CCS"~~ "SCH" means the ~~Crippled Children Services~~ Services for Children with Handicaps Program.

9. "~~CCS~~ SCH adjusted income" means the income figure derived after ~~CCS~~ SCH applies cost-sharing calculations pursuant to Rule 7 MCAR §§ 1.654 (B) (4).

10. "Comprehensive Care Center" (Applicable to Services for Hemophiliacs Only) means a medical facility in which a multidisciplinary team coordinates a program of total care for hemophiliacs, including emergency and consultation services.

11. "Cost-sharing" means the financial participation in the cost of treatment service(s) on the part of the applicant and established on the basis of ability to pay pursuant to these rules.

12. "Cost-sharing schedule" means the schedule set out in Rule 7 MCAR § 1.654 (B)(4) which specifies income levels by number of members in the household and the corresponding percentage of that income level an applicant shall be required to share in the cost of treatment service(s), depending upon the level of their GGS SCH adjusted income.

13. "Diagnostic evaluation" means the initial history, examination and necessary tests to establish the diagnosis and outline the plan of treatment. This evaluation is performed by a team of professionals under the direction of a physician who is board-certified or board-eligible in a specialty area.

14. "Federal Act" means the Social Security Act, as amended, Title V, (USC 42, Chapter 7).

15. "Hemophilia" means a bleeding tendency resulting from a genetically determined deficiency and/or abnormality of a blood plasma factor or component.

16. "Household member" means any of the following individuals who shall be counted as part of a household for the purposes of these rules:

    a. Spouse

    b. Parent(s) and their children who are not self-supporting whether residing in the household or absent from the home.

    c. The unborn child/children of a current pregnancy of a spouse. Self-supporting individuals 18 years and over shall not be included as members of the household.

17. "Household member deduction" means an amount of $1,000 for each household member which is deducted from the total of the includable assets.

18. "Includable Assets" means cash and those fluid assets readily convertible into cash such as commercial paper and negotiable paper instruments. The amount of these instruments is added by ~~GGS~~ SCH to the adjusted gross income. Includable assets include:

    a. Cash

    b. Checking accounts

    c. Certificates of deposit

    d. Savings accounts

    e. Bonds

    f. Stocks

    g. Income not reportable to IRS

19. "~~Long-term-physically~~ Handicapping condition" means a ~~condition based-upon-the-diagnostic-evaluation-and-approved-by-GGS,-which cannot-be-resolved-or-significantly-influenced-within-two-years of-the-date-of-initial-application~~ physical condition which requires extended, sequential, medical, surgical and/or rehabilitative intervention as determined by a diagnostic evaluation and approved by SCH.

20. "Medical Director" means the physician assigned responsibility by the Commissioner of Health for the administration and management of ~~GGS~~ SCH in the State of Minnesota.

21. "One-person household" means any of the following individuals who shall be counted as a one-person household for the purposes of these rules:

    a. An adult living alone.

    b. An adult living with individual(s) other than a spouse or children who are not self-supporting.

    c. A child living with a relative other than a parent or legal guardian.

    d. An individual 18 years of age or over who is a self-supporting individual and living with parent(s).

22. "Prior authorization" means ~~an~~ a written agreement between ~~GGS~~ SCH and a service provider which details service(s) requested for payment by ~~GGS~~ SCH for the benefit of an applicant. The service(s) and conditions of payment must be approved by an agent of ~~GGS~~ SCH prior to provision of the service(s).

23. "Reimbursement" means the payment by ~~GGS~~ SCH to a service provider for diagnostic evaluation or treatment service(s) of ~~GGS~~ SCH eligible individuals.

24. "Self-supporting individual" means an individual who contributes 50% or more toward his/her living costs.

25. "Service provider" means any of those facilities and personnel whose services are requested by ~~GGS~~ SCH and who meet the criteria for participation as specified in these rules.

26. "State gross median income" means the income level at which 50% of the people in the state have incomes higher than the median and 50% of the people have incomes which are lower, as computed by the Minnesota Department of Employment Services in 1977.

27. "Third-party reimbursement sources" means a third-party payer, other than the applicant who pays for service(s) not directly received by the payer, such as insurance (including Health Maintenance Organizations) and/or Title XIX (Medical Assistance).

28. "Title XIX" (Medical Assistance) means the program authorized by the Social Security Act USC 42, Section 1901-1910 to provide reimbursement for medical care for individuals whose resources do not enable them to purchase such care.

29. "Treatment service(s)" means the ongoing medical case management for a child diagnosed as having a ~~long-term-physically~~ handicapping condition. This medical case management includes definitive medical, surgical, dental, rehabilitative and follow-up services related to the condition.

30. "Treatment plan" means a written statement developed by a physician who is board-certified or board-eligible in a specialty area, in concert with other professionals and which delineates the service(s) required to correct or ameliorate an individual's physically handicapping condition.

7 MCAR § 1.652 Applicant Eligibility for Diagnostic Evaluation

A. An applicant shall complete an application provided by ~~CCS~~ SCH as described in Rule 7 MCAR § 1.654 (A). Any applicant, regardless of income, who meets all of the following criteria shall be eligible for a diagnostic evaluation authorized by ~~CCS~~ SCH:

1. A resident of the State of Minnesota.

2. A child under 21 years of age or an adult 21 years of age or

over with cystic fibrosis or hemophilia.

3. A child who is suspected to be a child with a handicap.

B. In addition to the above criteria:

1. An applicant shall be required to make use of available third-party reimbursement sources for the examinations and tests necessary for a diagnostic evaluation. There shall be no out-of-pocket cost to the applicant.

2. Prior written authorization shall be required for a diagnostic evaluation to be reimbursed in full or for that part not reimbursed by third-party payers by GGS SCH.

7 MCAR § 1.653 Applicant Eligibility for Treatment Services

A. An applicant shall complete an application provided by GGS SCH and described in Rule 7 MCAR § 1.654 (A). Any applicant who meets all of the following criteria shall be eligible for GGS SCH reimbursement to service providers for the cost of treatment service(s):

1. A resident of the State of Minnesota.

2. A child under 21 years of age or an adult 21 years of age or older with cystic fibrosis or hemophilia.

3. A child who has a diagnosed ~~long-term-physically~~ handicapping condition as defined in these rules.

B. In addition to the above criteria:

1. An applicant shall agree to participate in cost-sharing if any is required, according to the specifications set out in Rule 7 MCAR § 1.654 (B).

2. An applicant shall be required to make use of available third-party reimbursement sources for treatment service(s).

3. Prior written authorization shall be required for treatment service(s) to be reimbursed in full or in part by GGS SCH.

C. An applicant who meets all of the criteria and requirements for eligibility, but whose handicapping condition may ~~be-of-a-short-term-nature,~~ not require extended or sequential care, shall be eligible for GGS SCH reimbursement to service providers in those instances where the cost of treatment is anticipated to exceed 40% of the applicant's adjusted gross income as defined in these rules.

7 MCAR § 1.654 Application and Cost-sharing for Applicant(s)

A. Application for Service(s)

1. GGS SCH shall provide an application form upon request. Each submitted application shall contain a signed statement by the applicant that the information given is true and complete to the best of his/her ability and knowledge.

2. GGS SCH shall review the completed application within 30 days of receipt. This review determines whether the applicant is eligible for GGS SCH reimbursement of treatment service(s) pursuant to Rule 7 MCAR § 1.653 (A) and determines any cost-sharing requirements.

3. GGS SCH shall notify the applicant in writing of any decision related to eligibility for GGS SCH reimbursement to service providers for service(s).

4. For applicants for treatment service(s), ~~GGS~~ SCH shall prepare the cost-sharing agreement, if cost-sharing is indicated under Rule 7 MCAR § 1.654 (B). An applicant shall not be eligible to have treatment service(s) authorized through ~~GGS~~ SCH until the cost-sharing agreement is signed by the applicant and received in the ~~GGS~~ SCH office.
5. An applicant who is determined ineligible for reimbursement of treatment costs may reapply when and if he/she feels there are changes of circumstance which are related to the eligibility criteria as contained in these rules.
6. The period in which an applicant shall remain eligible for ~~GGS~~ SCH authorization for reimbursement to service providers of treatment costs shall be as follows:
   a. One year from the date of receipt by ~~GGS~~ SCH of the signed cost-sharing agreement, when cost-sharing is required.
   b. One year from the date of the original eligibility determination, when no cost-sharing is required.
   c. ~~GGS~~ SCH ~~may~~ shall make an exception regarding the beginning date of eligibility in those instances where the child is in an unanticipated treatment situation and the applicant was unaware of the program before this time. Where the time required to process the application will cause delay in the provision of treatment service(s), the documented, initial contact with ~~GGS~~ SCH ~~may~~ shall be considered the beginning of eligibility if the application and signed cost-sharing agreement are received within 60 days of this initial contact.

7. GGS SCH shall send the applicant written notification of the date upon which eligibility begins.

8. To maintain eligibility, an applicant must complete another application at the end of the eligibility period.

B. Cost-sharing

1. Any applicant whose GGS SCH adjusted income as defined and described in Rule 7 MCAR § 1.651 (B)(9) is above 60% of the State gross median income shall be required to share in the treatment costs of all service(s) authorized by GGS SCH. GGS SCH shall reimburse service providers for remaining expenses for authorized treatment service(s) which are not covered by the applicant's cost-sharing or third-party reimbursement sources.

2. No cost-sharing shall be required of an applicant who is currently eligible for Medical Assistance (Title XIX), a ward of the State or whose GGS SCH adjusted income falls below 60% of the State gross median income.

3. The adjusted gross income used in any cost-sharing calculations shall be that of the applicant as defined in Rule 7 MCAR § 1.651 (B)(4). The income of a step-parent who does not adopt a child is not considered in cost-sharing calculations.

4. The amount of cost-sharing required of an applicant is determined in the following manner:

Step #1: The includable assets are totalled. If applicable, the household member deduction is subtracted from this total.

Step #2: The amount derived in Step #1 is then added to the adjusted gross income.

Step #3: The total of the allowable deductions is subtracted

from the amount derived in Step #2. This figure indicates the GGS SCH adjusted income.

Step #4: The percentage that the applicant must share in the cost of treatment is based on the applicant's GGS SCH adjusted income level and on the number of members in the household. This percentage is calculated according to the following chart.

5. Adjustments in cost-sharing ~~may~~ shall be made when extenuating circumstances occur which may alter the ability of an applicant to assume cost-sharing in the amount indicated. The following constitute criteria for a review of an applicant's cost-sharing requirement during the eligibility period:
   a. An increase or decrease of 5% in the annual adjusted gross income from that indicated on the application.
   b. A change in the number of members included in the household from that indicated on the application.
   c. Uninsured property damage of at least $2,500.
   d. Extraordinary expenses for travel, lodging, child care incurred by families as a result of current treatment of eligible children.
6. An applicant shall be responsible for reporting any change in the number of household members or a change of 5% of the adjusted gross income to GGS SCH within 15 days. Failure to provide such information shall constitute grounds for review of an applicant's cost-sharing.

~~GGS-COST-SHARING-SCHEDULE~~
SCH COST-SHARING SCHEDULE

For each number of household members, the beginning income level on the schedule represents the range of income from 0 to 60% o the state gross median income. Increments of $1,000 have been used to establish each succeeding income level for that size household in 1977. The percentage at the left of the schedule rises 1% for every $1,000 rise in the GGS SCH adjusted income level.

ercentage which eligible pplicants share in the ost of treatment	Income Levels by Number of Members in the Household				
	1	2	3	4	5
0	0 - $5,606	0 - $7,332	0 - $9,057	0 -$10,782	0 -$12,507
1	5,607 - 6,606	7,333 - 8,332	9,058 - 10,057	10,783 - 11,782	12,508 - 13,507
2	6,607 - 7,606	8,333 - 9,332	10,058 - 11,057	11,783 - 12,782	13,508 - 14,507
3	7,607 - 8,606	9,333 - 10,332	11,058 - 12,057	12,783 - 13,782	14,508 - 15,507
4	8,607 - 9,606	10,333 - 11,332	12,058 - 13,057	13,783 - 14,782	15,508 - 16,507
5	9,607 - 10,606	11,333 - 12,332	13,058 - 14,057	14,783 - 15,782	16,508 - 17,507
[illegible]	10,607 - 11,606	12,333 - 13,332	14,058 - 15,057	15,783 - 16,782	17,508 - 18,507
7	11,607 - 12,606	13,333 - 14,332	15,058 - 16,057	16,783 - 17,782	18,508 - 19,507
8	12,607 - 13,606	14,333 - 15,332	16,058 - 17,057	17,783 - 18,782	19,508 - 20,507
9	13,607 - 14,606	15,333 - 16,332	17,058 - 18,057	18,783 - 19,782	20,508 - 21,507
10	14,607 - 15,606	16,333 - 17,332	18,058 - 19,057	19,783 - 20,782	21,508 - 22,507
11	15,607 - 16,606	17,333 - 18,332	19,058 - 20,057	20,783 - 21,782	22,508 - 23,507
12	16,607 - 17,606	18,333 - 19,332	20,058 - 21,057	21,783 - 22,782	23,508 - 24,507
13	17,607 - 18,606	19,333 - 20,332	21,058 - 22,057	22,783 - 23,782	24,508 - 25,507
14	18,607 - 19,606	20,333 - 21,332	22,058 - 23,057	23,783 - 24,782	25,508 - 26,507
15	19,607 - 20,606	21,333 - 22,332	23,058 - 24,057	24,783 - 25,782	26,508 - 27,507
16	20,607 - 21,606	22,333 - 23,332	24,058 - 25,057	25,783 - 26,782	27,508 - 28,507
17	21,607 - 22,606	23,333 - 24,332	25,058 - 26,057	26,783 - 27,782	28,508 - 29,507
18	22,607 - 23,606	24,333 - 25,332	26,058 - 27,057	27,783 - 28,782	29,508 - 30,507

Add 1% per thousand for higher incomes	6	7	8	9	10
0	0 - 14,232	0 - 14,556	0 - 14,879	0 - 15,203	0 - 15,526
1	14,233 - 15,232	14,557 - 15,556	14,880 - 15,879	15,204 - 16,203	15,527 - 16,526
[illegible]	15,233 - 16,232	15,557 - 16,556	15,880 - 16,879	16,204 - 17,203	16,527 - 17,526
3	16,233 - 17,232	16,557 - 17,556	16,880 - 17,879	17,204 - 18,203	17,527 - 18,526
4	17,233 - 18,232	17,557 - 18,556	17,880 - 18,879	18,204 - 19,203	18,527 - 19,526
5	18,233 - 19,232	18,577 - 19,556	18,880 - 19,879	19,204 - 20,203	19,527 - 20,526
6	19,233 - 20,232	19,557 - 20,556	19,880 - 20,879	20,204 - 21,203	20,527 - 21,526
7	20,233 - 21,232	20,557 - 21,556	20,880 - 21,879	21,204 - 22,203	21,527 - 22,526
8	21,233 - 22,232	21,557 - 22,556	21,880 - 22,879	22,204 - 23,203	22,527 - 23,526
9	22,233 - 23,232	22,557 - 23,556	22,880 - 23,879	23,204 - 24,203	23,527 - 24,526
10	23,233 - 24,232	23,557 - 24,556	23,880 - 24,879	24,204 - 25,203	24,527 - 25,526
11	24,233 - 25,232	24,557 - 25,556	24,880 - 25,879	25,204 - 26,203	25,527 - 26,526
12	25,233 - 26,232	25,557 - 26,556	25,880 - 26,879	26,204 - 27,203	26,527 - 27,526
13	26,233 - 27,232	26,557 - 27,556	26,880 - 27,879	27,204 - 28,203	27,527 - 28,526
14	27,233 - 28,232	27,557 - 28,556	27,880 - 28,879	28,204 - 29,203	28,527 - 29,526
15	28,233 - 29,232	28,557 - 29,556	28,880 - 29,879	29,204 - 30,203	29,527 - 30,526
16	29,233 - 30,232	29,557 - 30,556	29,880 - 30,879	30,204 - 31,203	30,527 - 31,526
17	30,233 - 31,232	30,557 - 31,556	30,880 - 31,879	31,204 - 32,203	31,527 - 32,526
18	31,233 - 32,232	31,557 - 32,556	30,880 - 32,879	32,204 - 33,203	32,527 - 33,526

7. The amount that an eligible applicant shall share in the cost of treatment shall remain the same regardless of the number of children in the household eligible for treatment under the GGS SCH Program. For example, if the cost-sharing amount is $780, this amount is not changed if there are two or more children in the household eligible for service.

7 MCAR § 1.655 Reimbursement for Service(s)

A. GGS SCH shall only reimburse for diagnostic evaluation and/or treatment service(s) for which a prior written authorization has been provided in a format designated by GGS SCH.

B. Emergency authorization of reimbursement for treatment service(s) may shall be provided by GGS SCH in situations which are later determined by the GGS SCH Medical Director to be life threatening or to have the potential for irrevocable damage, injury or long-term consequences if treatment is not provided immediately. In these instances, GGS SCH shall be notified by the physician or hospital staff within 72 hours after admission to a hospital. Eligibility for further authorization shall be determined according to the criteria contained in these rules.

C. Limitations on Authorization of Reimbursement for Treatment Service(s)

1. GGS SCH shall authorize reimbursement to a service provider only for treatment that is part of the treatment plan for an individual's handicapping condition.

2. GGS SCH shall not authorize reimbursement for the treatment of conditions determined by GGS SCH to be primarily cosmetic in nature.

3. ~~CCS~~ SCH shall not authorize reimbursement for costs of equipment such as hospital beds or wheel chairs unless no other resource is available.

4. Within any 12-month period, ~~CCS~~ SCH shall pay no more than ~~$7,500~~ $10,000 for the care of an individual.

5. ~~CCS~~ SCH shall not authorize reimbursement for treatment service(s) not associated with an individual's eligible condition. An exception ~~may~~ shall be made and routine care ~~may~~ shall be authorized by the ~~CCS~~ SCH Medical Director when, as the result of the eligible condition, it is more probable than not that a life threatening situation or irrevocable damage or injury might occur during what otherwise would be routine care.

6. ~~CCS~~ SCH shall not authorize reimbursement for treatment services for individuals 21 years of age or over with hemophilia except as specified in 7 MCAR § 1.655 (D).

D. Reimbursement for care and treatment of hemophiliacs 21 years of age or over shall be available for:

1. Blood, blood components, blood derivatives.

2. Home infusion kits.

3. Other chemical agents suitable for effective treatment in hospitals, medical and dental facilities and at home.

4. Orthopedic braces, splints and special shoes.

5. Periodic evaluation at a comprehensive care center.

E. The following services are not reimbursable under this rule for hemophiliacs 21 years of age or over:

1. Hospital care other than that hospital care necessary to provide those services as specified in 7 MCAR § 1.655 (D).
2. Physician care other than that physician care necessary to provide those services as specified in 7 MCAR § 1.655 (D).
3. Dental care other than that dental care necessary to provide those services as specified in 7 MCAR § 1.655 (D).
4. Medical transportation unless it is a medical emergency as determined by the Medical Director.

7 MCAR § 1.656 Administrative Review Procedures

A. An applicant and/or staff person of any agency may request, at any time, a review by the Administrative Review Committee of their eligibility status or cost-sharing requirement.
   1. A written request for review shall be submitted to the GGS SCH Medical Director containing the reasons for the request, the issues involved and a brief summary of any previous actions.
   2. The review shall take place within 30 days of the receipt of the request. The applicant shall be notified at least 15 days in advance of the date, time and place of the review.
   3. If an applicant, through no fault of his/her own, cannot attend the review and wishes to do so, the reasons should be stated in writing. GGS SCH will then reschedule the review.
   4. The applicant and/or his/her representative may be present at this review. During this review, the applicant shall have further opportunity to explain his/her circumstances.

5. ~~GGS~~ SCH shall inform the applicant in writing of the decision and the grounds upon which the decision is based.

B. Formal Hearing

In the event that an applicant seeks to appeal the decision of ~~GGS~~ SCH such an appeal shall be conducted by the Minnesota Department of Health pursuant to the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

7 MCAR § 1.657 Responsibilities Between ~~GGS~~ SCH and Service Providers

A. ~~GGS~~ SCH

1. ~~GGS~~ SCH shall supply, with the written consent of the applicant, referral information to service providers for applicants authorized to receive diagnostic evaluations or treatment service(s).
2. ~~GGS~~ SCH shall pay service providers at the same rates for medical, dental, and hospital care up to the maximum allowable charges as set forth in the Medical Assistance Rates Schedule (revised September 7, 1978) established by the Minnesota Department of Public Welfare (Title XIX) pursuant to its authority found in 12 MCAR § 2.047.
   a. In instances where there are no established rates, ~~GGS~~ SCH shall reimburse service providers at rates based upon the following criteria:
      i. complexity of service.
      ii. time involved in completing the service.
      iii. training and skills of the service provider
      iv. reasonableness of fees in the context of the community.

b. GGS SCH is the payer of last resort. GGS SCH reimbursement of treatment costs to service providers shall be made only after arrangements have been made by the service provider to collect third-party and cost-sharing payments.

3. GGS SCH shall review reimbursement requests submitted by service providers within 45 days of receipt. This review shall be made to assure that the service(s) rendered were in keeping with those detailed on the authorization form and that arrangements have been made by the service provider for all other third-party and cost-sharing payments.

4. Potential service providers must submit their credentials to the GGS SCH Medical Director. Those service providers who shall be utilized by GGS SCH shall meet the following criteria and, if acceptable, indicate in writing a willingness to participate in the GGS SCH Program in keeping with the goals and procedures of GGS SCH:

   a. Hospitals and specialized medical centers shall be approved by the Joint Commission on the Accreditation of Hospitals (JCAH) or their appropriate accreditation body and licensed by the Minnesota Department of Health or their respective states.

   b. Physicians and dentists shall:

      1) Be board-eligible or board-certified or, in the instances of dentists not certified, have demonstrated special expertise in pediatric dentistry either through the percentage of their patients, publications

they have written or training, and,

2) Be part of a multi-disciplinary group or work closely with other specialists to provide a comprehensive approach to the care of the identified handicapping conditions, and,

3) Be licensed to practice medicine and/or dentistry in Minnesota or their respective states.

c. Other service provider personnel shall be licensed by their respective boards or associations in the State of Minnesota. Those service provider personnel whose professions do not require licensure may be utilized when they have completed the training and experience requirement specified by the individual professional association to be considered qualified and the child's treatment plan indicates their services are necessary.

d. Service provider personnel who provide a product such as hearing aids or orthopedic appliances shall be registered with the Department of Public Welfare as approved Title XIX vendors.

5. Service providers who are not approved to provide service(s) to GGS SCH eligible children may request reconsideration of their credentials by the GGS SCH Medical Director. In the event that a service provider seeks to appeal the decision of GGS SCH, such an appeal shall be conducted by the Minnesota Department of Health pursuant to the Minnesota Administrative Procedures Act and the Rules of the Office of Hearing Examiners.

6. ~~CCS~~ SCH shall maintain case records containing administrative, medical, and case planning information. and shall, consistent with state and federal law and rule, protect the privacy of ~~The~~ individual case records. ~~are classified as private in keeping with the definitions and provisions of Minnesota Statutes 15, Chapter 401.~~

B. Service Providers

1. A service provider shall receive prior written authorization before providing service to a ~~CCS~~ SCH eligible child, with the exception of emergency situations as specified in Rule 7 MCAR § 1.655 (B).

2. A service provider shall supply case report and cost-related information in a format as specified by ~~CCS~~ SCH.

3. A service provider shall arrange for third-party reimbursement and the cost-sharing prior to billing ~~CCS~~ SCH for the remaining costs. In instances where third-party reimbursements are delayed more than 90 days, a service provider may bill ~~CCS~~ SCH for reimbursement and refund ~~CCS~~ SCH within 90 days of the receipt of third-party reimbursements.

4. A service provider shall not charge the applicant for treatment service(s) authorized by ~~CCS~~ SCH beyond the cost-sharing amount detailed on the authorization form.

ILLUSTRATION OF COST-SHARING DETERMINATION

Footnote 1

Step #1	Total of Includable Assets	$ 6,000
	-Household Member Deduction, if Applicable	- 4,000
		$ 2,000
	$_____	
Step #2	Adjusted Gross Income	$ 12,000
	+Amount Derived in Step #1	+ 2,000
		$ 14,000
	$_____	
Step #3	Amount Derived in Step #2	$ 14,000
	-Total of Allowable Deductions	- 1,300
	$GGS SCH ADJUSTED INCOME	$ 12,700

Step #4 Using the cost-sharing schedule, take the percentage for the income level indicated in Step#3 and adjusted for the number of members in the household. The figure obtained from this calculation equals the amount of cost-sharing an applicant will be required to share for the cost of treatment.

Number of members in the household = 4. The percentage for this income level is 2%. 2% of $12,700 = $254.00. $254.00 is the amount required for this applicant.

APPROVED AS TO FORM AND LEGALITY

NOV. 30 1979 19

WARREN SPANNAUS, ATTORNEY GENERAL

BY Lee E. Shurley

SPECIAL ASSISTANT ATTORNEY GENERAL

STATE OF MINNESOTA
DEPARTMENT OF STATE
FILED
NOV 30 1979
Joan Anderson Growe
Secretary of State

1:30 p.m.

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Rules of the Minnesota Department of Health Relating to the Services to Children With Handicaps and Adults With Cystic Fibrosis and Hemophilia for Eligibility, Cost-Sharing and Reimbursement

SUPPLEMENTAL FINDINGS OF FACT, CONCLUSIONS AND ORDER

The above-entitled rules were adopted in the FINDINGS OF FACT, CONCLUSIONS AND ORDER dated August 29, 1979, a part of the record herein, and thereafter submitted to the Attorney General for his review pursuant to Minn. Stat. § 15.0412, subd. 4 (1978). Inasmuch as the rules as initially adopted in the FINDINGS OF FACT, CONCLUSIONS, AND ORDER dated August 29, 1979, were not approved by the Attorney General's Office, for reasons enumerated in a memo dated November 5, 1979, to George R. Pettersen, MD, Commissioner of the Department of Health, from Lee E. Sheehy, Special Assistant Attorney General, the Commissioner now makes the following:

FINDINGS OF FACT

1. Inasmuch as the title of the rules as initially adopted refers only to children with handicaps, and inasmuch as the rules govern adults suffering from cystic fibrosis and hemophilia, it is reasonable to reference the adult category in the title of the rules;

2. 7 MCAR § 1.651A as initially adopted contains a citation to state appropriations made in 1977. Inasmuch as subsequent appropriations should be referenced in the rules, it is reasonable to delete reference to a specific appropriation and to reference Minnesota law in general;

3. Inasmuch as 7 MCAR § 1.651B(21)(d) misspells the word "individual," this misspelling should be corrected;

4. 7 MCAR § 1.651B(29) as initially adopted contains the phrase "long term physically handicapping condition." Inasmuch as this term was deleted during the course of the hearing process as a separate definition, it is reasonable to delete the term in this section;

5. 7 MCAR § 1.653C as initially adopted contains the phrase "be of a short term nature." Inasmuch as the conceptual basis for this term rests with those conditions not requiring extended or sequential care, it is reasonable to specifically reference a handicapping condition which may "not require extended or sequential care," and to delete reference to a short term condition;

6. 7 MCAR §§ 1.654B(5), 1.655B and C(5), and 1.654A(6)(c) as originally adopted use the verb "may." Inasmuch as these sections refer to the exercise of governmental discretion, and inasmuch as the use of the verb "may" could be interpreted to afford the agency unbridled discretion, it is reasonable to delete the verb "may" in these sections when referring to the exercise of governmental discretion and substitute therefor the verb "shall";

7. Inasmuch as 7 MCAR § 1.657A(6) contains an incorrect citation to state law, the citation shall be deleted from the rules as finally adopted;

8. The Commissioner reaffirms the findings of fact contained in the FINDINGS OF FACT, CONCLUSIONS AND ORDER, dated August 29, 1979, said findings being fully incorporated into and made a part of these findings, except as they may be inconsistent with findings 1 through 7 herein;

CONCLUSIONS OF LAW

The Commissioner reaffirms the conclusions contained in the FINDINGS OF FACT, CONCLUSIONS AND ORDER dated August 29, 1979, said conclusions being fully incorporated and made a part hereof, except as such conclusions may be inconsistent with findings 1 through 8, herein.

ORDER

The Rules Relating to the Services for Children With Handicaps and Adults With Cystic Fibrosis and Hemophilia for Eligibility, Cost-Sharing and Reimbursement identified as 7 MCAR §§ 1.651-1.657 are found to be reasonable, necessary and supported by the evidence contained in the records, and are hereby approved and adopted pursuant to the authority vested in me by Minn. Stat. §§ 144.05, 144.06, 144.07, 144.09, 144.10, 144.11, and 144.12 (1978). Further, pursuant to Minn. Stat. § 16.125, the Department of Reorganization Order No. 101, dated March 2, 1979, is vested within the Department of Health authority to implement Minn. Stat. §§ 250.05, 256.01, subd. 2(3) and (5), 256.011, 257.175, and 260.35 (1978) insofar as these statutes concern services for children with handicaps. Further authority, specifically regarding services for persons with cystic fibrosis and hemophilia, is found in Minn. Stat. § 144.146 (1978) and Minn. Laws 1977, ch. 453, § 24.

Dated: November 15, 1979

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

George R. Petterson M.D.

GEORGE R. PETTERSEN, MD
Commissioner of Health

TH-79-030-PE

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF HEALTH

IN THE MATTER OF PROPOSED RULES)
RELATING TO CRIPPLED CHILDREN'S)
SERVICES CRITERIA, PROCEDURES)
AND RESPONSIBILITIES FOR ELIGI-)
BILITY, COST-SHARING AND REIM-)
BURSEMENT.)

SUPPLEMENTAL REPORT OF
THE CHIEF HEARING EXAMINER

WHEREAS, on September 7, 1979, the Department of Health submitted the above-entitled rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. § 15.052, Subd. 4, and 9 MCAR § 2.110; and

WHEREAS, on September 10, 1979, the Chief Hearing Examiner issued his Report finding that the rules as proposed to be adopted were not substantially different from those proposed at the public hearing and that the Department of Health had met all requirements of Minn. Stat. § 15.0412, subd. 4; and

WHEREAS, the Department of Health subsequently submitted the rules and the record of the proceedings to the Attorney General for his review as to form and legality pursuant to Minn. Stat. § 15.0412, subd. 4; and

WHEREAS, the Attorney General recommended to the Department of Health that certain of the rules be amended; and

WHEREAS, the Department of Health has now resubmitted the rules to the Chief Hearing Examiner for his review; and

WHEREAS, the Chief Hearing Examiner finds that the changes made in the rules do not make the rules substantially different from those proposed at the public hearings.

NOW, THEREFORE, upon receipt of this Report, the Department of Health has the responsibility of resubmitting the complete hearing record and the rules as adopted by the Department to the Attorney General, notifying all persons who requested to be informed that the hearing record has been resubmitted to the Attorney General, and publishing in the State Register, all pursuant to Minn. Stat. § 15.0412, subd. 4.

Dated this 28th day

of November, 1979.

Duane R. Harves

DUANE R. HARVES
Chief Hearing Examiner

ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - Health

Office Memorandum

TO : Lee Sheehy
Special Assistant
Attorney General
G-25 Administration Bldg.

DATE: November 27, 1979

FROM : Terry P. O'Brien
Special Assistant
Attorney General

PHONE: 341-7272

SUBJECT: Rules of the Minnesota Department of Health Relating to the Services for Children with Handicaps and Adults with Cystic Fibrosis and Hemophilia for Eligibility, Cost-Sharing and Reimbursement

Enclosed for your review and eventual filing with the Secretary of State are the files which you had forwarded to the Department of Health by memo dated November 5, 1979. The order and arrangement of the files is the same as they were when you forwarded them to the Department. However, I have added three copies of the finally revised rules, entitled "Final Rules," to File #1 and a new copy of the final rules to files numbered 2 and 3. The final rules note new language with underlining and deleted language with cross-out. Also included in files numbered 1, 2, and 3 are the Supplemental Findings of Fact, Conclusions and Order issued by the Commissioner of Health on November 15, 1979, and the Report of the Chief Hearing Examiner.

If there are any problems or if you have any questions concerning these documents, please do not hesitate to contact me. Thank you.

TPO:ejg

Enclosures

PRINTED ON RECYCLED PAPER

Our File #552

ADMIN 1000 (Rev. 1/78)

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL

Office Memorandum

GEORGE R. PETTERSEN, M.D.
Commissioner
TO : Department of Health

DATE: November 5, 1979

Attn.: Terry O'Brien

FROM : LEE E. SHEEHY
Special Assistant
Attorney General

PHONE: 296-1288

SUBJECT: In the Matter of Proposed Rules Relating to Crippled Childrens' Services Criteria, Procedures and Responsibilities For Eligibility, Cost Sharing and Reimbursement.

The above-captioned rules have not been approved by this office for the below-enumerated reasons. After agency consideration of these reasons and appropriate action, if any, the rules must be resubmitted to the Chief Hearing Examiner prior to resubmittal to this office. If the rules are resubmitted to this office, please ensure that the original of the Order Adopting and the Rules as Adopted accompanies the materials resubmitted, as they are necessary for filing with the Secretary of State.

The rules have not been approved for the following reasons:

1. The title of the rules is misleading in that it refers only to children with handicaps. However, the rules govern adults suffering from cystic fibrosis and hemophilia. A reference to this adult category should be added to the title.

2. 7 MCAR § 1.651 A contains a citation to state appropriations made in 1977. After a brief review of this appropriation, it appears that those monies may well have expired and are no longer applicable. Further, a question must be raised about subsequent appropriations which should be referenced in these rules. Perhaps, a general reference to "funds appropriated under Minnesota law" would be more appropriate than a listing of a specific law or laws.

3. 7 MCAR § 1.651 B (21)(d) contains the misspelling of the word "individual."

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4. 7 MCAR § 1.651 B (29) contained the phrase "long term physically handicapping condition" as originally proposed. During the hearing process the definition and the concept were stricken from the rules because of concerns raised by the United States Department of Health, Education and Welfare. See Hearing Examiner's Finding No. 9(d). The Hearing Examiner then recommended that the phrase be stricken where it appeared in the rule. See Hearing Examiner's Finding No. 11. Based on these findings, it appears that the phrase should also be stricken from Section 1.651 B (29). Secondly, the agency may wish to reconsider reference to the phrase "short term" in Section 1.654 C in light of the changes in these rules.

5. The use of the word "may" in several areas of the rules which govern the rights of and procedures available to the public afford the agency unbridled discretion. The Administrative Procedure Act requires that rules contain every statement of general applicability and future effect. The use of the word "may" by the agency permits the agency to consider criteria and matters beyond those set forth in the rule. If it is the agency's intent to consider such criteria or other matters, those matters should be promulgated as a part of the rule. Otherwise, the word "shall" must be used. An example of this deficiency in the rules appears in 7 MCAR § 1.654 B (5). The rule sets forth the criteria upon which adjustments in cost-sharing will be considered. However, use of the word "may" permits the agency to consider criteria other than those listed in the rule. If the agency has other criteria which it wishes to consider, those criteria should be included in the rule. Otherwise, the word "shall" must be used. Additional examples of this problem are evident in 7 MCAR § 1.655 B and C (5) and 7 MCAR § 1.654 A (6)(c).

7. 7 MCAR § 1.657 A (6) has an incorrect citation to state law governing data practices of Minnesota Government.

If you have any questions, do not hesitate to contact me.

LES/bw
Encl.
cc: Duane Harves
Marshall Whitlock

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ADMIN 1000 (Rev. 1/78)
SF-00006-01

STATE OF MINNESOTA

DEPARTMENT ATTORNEY GENERAL - Health

Office Memorandum

TO : JOANNE HINDERAKER
Special Assistant
Attorney General

DATE: October 16, 1979

FROM : TERRY P. O'BRIEN
Special Assistant
Attorney General

PHONE: 341-7272

SUBJECT: Rules of the Minnesota Department of Health Relating to the Services for Children With Handicaps--Criteria, Procedures and Responsibilities for Eligibility, Cost-Sharing and Reimbursement

Enclosed for review and filing are three files containing documentation in support of the adoption of the above-referenced rules. The rules were not unusually controversial and their promulgation did not present any special problems. I would appreciate it if following filing with the Secretary of State you would return files numbered 2 and 3 to me.

If you have any questions, please do not hesitate to contact me. Thank you.

TPO:rlb

Enclosure

RECEIVED
OCT 17 1979 5:00 P.M.
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

RECEIVED
OCT 18 1979
ATTORNEY GENERAL
ADMINISTRATIVE AGENCIES

PRINTED ON RECYCLED PAPER

cases. However, because of more accurate data on the number of individual cases whose costs of care actually go over the present established limit, CCS feels that the ceiling on liability for care can reasonably be raised to $10,000. This increase would enhance the program's ability to adequately serve a significant number of children whose costs of care fall over the current ceiling liability and not diminish the program's capacity for providing some financial assistance to a large number of individuals.

development. Consequently, the title of the program no longer accurately describes the population of served children.

The title of the Crippled Children Services program could conceivably lead some individuals to believe that the services of the program would not be appropriate to their needs. In addition, the old program title has a stigmatizing effect and may discourage new families from initiating contact with the program.

The new title, Services for Children with Handicaps, is a reasonable replacement. The program provides services for those children who have a handicapping condition or a suspected handicapping condition, and does not provide general health care to well children. This title appropriately allows the public to be aware of the general purpose of the program and for whom its services are intended.

AMENDMENT TWO

It is proposed that 7 MCAR § 1.655 C.4 be amended to read as follows: Within any 12 month period, CCS shall pay no more than $10,000 for the care of an individual.

STATEMENT OF NEED AND REASONABLENESS

In order to adequately serve a significant number of children whose costs of care currently fall between the present ceiling of $6600 and the higher amount, the ceiling should be raised to $10,000. CCS does have limited funds available for treatment services based upon the federal formula contained in 42 CFR, Part A § 51a.123 and legislative appropriation. In an effort to provide some financial aid with the costs of treatment to a larger group of individuals, it is necessary and reasonable that CCS limit its liability on individual

Enclosure #1

DRAFT

Stat # 13

DEPARTMENT OF HEALTH

Proposed Rules Relating To Crippled Children Services Criteria, Procedures and Responsibilities for Eligibility, Cost-Sharing and Reimbursement

RECEIVED
MAR 30 1979
OFFICE OF HEARING EXAMINERS

Amendments to Rules as Proposed

Chapter Thirty-one: 7 MCAR §§ 1.651 - 1.657

Prior to public hearings scheduled to consider the proposed Minnesota Department of Health rules relating to Crippled Children Services criteria, procedures and responsibilities for eligibility, cost-sharing and reimbursement, Crippled Children Services (CCS) has decided to change the title of the program. At the hearings, Crippled Children Services will be proposing an amendment to the rules, as presented, which would allow CCS to accomplish this.

AMENDMENT ONE

The proposed amendment reads as follows:

It is proposed that the title of the Crippled Children Services (CCS) program in Minnesota shall be changed to Services for Children with Handicaps (SCH). All references to Crippled Children Services throughout the text of the proposed rules shall be changed to correspond to the new title.

STATEMENT OF NEED AND REASONABLENESS

The title of the Crippled Children Services (CCS) program has a long history dating from the program's creation as a result of the Social Security Act of 1935. Initially, CCS concerned itself primarily with children who had orthopedic problems. As CCS evolved over the years, other handicapping conditions were included. Today, the program offers services to children who have a broad range of handicapping conditions that interfere with their normal growth and

STATE OF MINNESOTA
DEPARTMENT OF ADMINISTRATION
REORGANIZATION NO. 101

Pursuant to Minnesota Statutes 1978, Section 16.125, the following administrative reorganization is made with the prior approval of the Governor.

In order to improve efficiency, to avoid duplication, and to supplement Reorganization Order No. 36 which became effective November 28, 1973, the powers, duties, or any combination thereof, relating to the functions, duties, and responsibilities of the Department of Public Welfare, Crippled Children Services Activity, which were not fully and completely transferred by Reorganization Order No. 36 to the Department of Health, are transferred by this reorganization order, and shall include, but not be limited to, those statutory powers, duties, functions, and responsibilities that are specifically cited and described below:

1. Minnesota Statutes 1978, Section 256.01, Subdivision 2(3) - insofar as it relates to the authority to administer and supervise all non-institutional services to eligible Crippled Children Services recipients including the power to promulgate procedural rules for this purpose pursuant to Minnesota Statutes 1978, Section 15.0412, Subdivision 3.

2. Minnesota Statutes 1978, Section 256.01, Subdivision 2(5) - insofar as it relates to authority to administer federal funds for dependent children eligible for Crippled Children Services including making rules to insure availability of medical care benefits.

3. Minnesota Statutes 1978, Section 256.011 - insofar as it relates to authority to accept and administer federal grants-in-aid to Crippled Children Services.

4. Minnesota Statutes 1978, Section 257.175 - insofar as it relates to the responsibility for promoting public awareness of laws protecting handicapped children eligible for services from Crippled Children Services.

5. Minnesota Statutes 1978, Section 250.05, Subdivision 6 - insofar as it relates to the authority to administer the state appropriation, to the extent available therefore, to Gillette Hospital Authority for services to crippled children.

6. Minnesota Statutes 1978, Section 260.35 - insofar as it relates to authority to arrange for such tests, examinations, and investigations as are necessary for the proper diagnosis, treatment, and care of dependent and/or neglected handicapped children eligible for Crippled Children Services.

In accordance with Minnesota Statutes 1978, Section 16.125, Subdivision 2, this order is effective upon filing with the Secretary of State and shall remain in effect until amended or superseded.

APPROVED:

3-1-79
Date

William G. Strusinski
Acting Commissioner
Department of Administration

Filed According to Law:

3/2/79
Date

Joan Anderson Growe
Secretary of State

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of Proposed Rules Relating to Crippled Childrens Services Criteria, Procedures and Responsibilities for Eligibility, Cost-Sharing and Reimbursement

ORDER FOR HEARING

To effectively implement Minn. Stat. §§ 144.05, 144.12, 144.07, 144.06, 144.09, 144.10, 144.11 (1978), the Minnesota Commissioner of Health deems it necessary to consider adoption of the proposed rules captioned above pursuant to the authority vested in him by the above-referenced statutes. Furthermore, to effectively implement Minn. Stat. §§ 256.01, subd. 2(3) and (5), 256.011, 257.175, 250.05, subd. 6, and 15.0412 (1978), the Commissioner of Health deems it necessary to consider adoption of the proposed rules captioned above under the authority vested in him by the Minnesota Department of Administration Reorganization No. 101 issued pursuant to Minn. Stat. § 16.125 (1978).

NOW, THEREFORE, IT IS ORDERED this 5th day of March, 1979, that a public hearing on the proposed rules captioned above be held in the Council Room of the St. Cloud City Hall, 314 St. Germain, St. Cloud, Minnesota, on Wednesday, April 25, 1979, commencing at 9:00 a.m. Following adjournment, the hearing shall be reconvened in Room 105, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Friday, April 27, 1979, commencing at 9:30 a.m., and continuing until all persons or representatives of associations or other interested groups have had an opportunity to be heard.

IT IS FURTHER ORDERED that notice of said hearing be published in the State Register and be given to all persons or representatives of associations or other interested groups who have registered their names with the Secretary of State for that purpose.

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

George R. Pettersen M.D.

GEORGE R. PETTERSEN, M.D.
Commissioner of Health

RECEIVED
MAR 5 1979
OFFICE OF HEARING
EXAMINERS

Stats #4

STATE OF MINNESOTA
COUNTY OF HENNEPIN

BEFORE THE MINNESOTA
COMMISSIONER OF HEALTH

In the Matter of Proposed Rules
Relating to Crippled Childrens
Services Criteria, Procedures and
Responsibilities for Eligibility,
Cost-Sharing and Reimbursement

NOTICE OF HEARING

Notice is hereby given that a public hearing in the above-entitled matter will be held pursuant to Minn. Stat. § 15.0412, subd. 4 (1978) in the Council Room of the St. Cloud City Hall, 314 St. Germain, St. Cloud, Minnesota, on Wednesday, April 25, 1979, commencing at 9:00 a.m. Following adjournment, the hearing shall be reconvened in Room 105, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota, on Friday, April 27, 1979, commencing at 9:30 a.m.

All interested or affected persons will have an opportunity to participate concerning the adoption of the proposed rules captioned above. Statements may be made orally and written material may be submitted. In addition, whether or not an appearance is made at the hearing, written statements or material may be submitted by mail to Peter Erickson, Hearing Examiner, at Room 300, 1745 University Avenue, Saint Paul, Minnesota 55104, telephone (612) 296-8118, either before the hearing or within five (5) days after the close of the hearing or for a longer period not to exceed 20 calendar days if ordered by the hearing examiner. All such statements will be entered into and become part of the record. Testimony or other evidence to be submitted for consideration should be pertinent to the matter at hand. For those wishing to submit written statements or exhibits, it is requested but not required that at least three (3) copies be furnished. In addition, it is suggested, to save time and avoid duplication, that those persons, organizations, or associations having a common viewpoint or interest in these proceedings join together where possible and present a single statement in behalf of such interests. The conduct of the hearing shall be governed by the rules of the Office of Hearing Examiners.

A copy of the proposed rules is attached hereto and made a part hereof.

Copies of the proposed rules are now available and at least one free copy may be obtained by writing to the Director, Crippled Childrens Services of the Minnesota Department of Health, Community Park Plaza, 2829 University Avenue Southeast, Minneapolis, Minnesota 55414. Additional copies will be available at the door on the date of the hearing.

NOTICE: The proposed rules are subject to change as a result of the rule hearing process. The Agency therefore strongly urges those who are potentially affected in any manner by the substance of the proposed rules to participate in the rule hearing process.

The statutory authority of the Commissioner to promulgate and adopt these rules is contained in Minn. Stat. §§ 144.05, 144.12, 144.07, 144.06, 144.09, 144.10, 144.11 (1978) and under State of Minnesota, Department of Administration Reorganization No. 101 pursuant to Minn. Stat. § 16.125 (1978). Further authority to implement these rules is found in Minn. Stat. §§ 256.01, subd. 2(3) and (5), 256.011, 257.175, 250.05, subd. 6, 260.35 and 15.0412 (1978).

Notice is hereby given that 25 days prior to the hearing, a statement of need and reasonableness will be available for review at the agency and at the Office of Hearing Examiners. This statement of need and reasonableness will include a summary of all of the evidence which will be presented by the agency at the hearing justifying both the need for and the reasonableness of the proposed amendments. Copies of the statement of need and reasonableness may be obtained from the Office of Hearing Examiners at a minimal charge.

In addition, please be advised that Minn. Stat. ch. 10A requires each lobbyist to register with the State Ethical Practices Board within five (5) days after he commences lobbying. A lobbyist is defined in Minn. Laws 1978, ch. 463, § 11 as any individual:

(a) Engaged for pay or other consideration, or authorized by another individual or association to spend money, who spends more than five hours in any month or more than $250, not including his own travel expenses and membership dues, in any year, for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials; or

(b) Who spends more than $250, not including his own traveling expenses and membership dues, in any year for the purpose of attempting to influence legislative or administrative action by communicating or urging others to communicate with public officials.

The statute provides certain exceptions. Questions should be directed to the Ethical Practices Board, 41 State Office Building, Saint Paul, Minnesota 55155, telephone (612) 296-5615.

Notice: Any person may request notification of the date on which the hearing examiner's report will be available, after which date the agency may not take any final action on the rules for a period of five working days. Any person may request notification of the date on which the hearing record has been submitted (or resubmitted) to the Attorney General by the agency. If you desire to be so notified, you may so indicate at the hearing. After the hearing, you may request notification by sending a written request to the hearing examiner (in the case of the hearing examiner's report), or to the agency (in the case of the agency's submission or resubmission to the Attorney General).

Dated: March 5, 1979

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

George R. Pettersen MD

GEORGE R. PETTERSEN, M.D.
Commissioner

State #8

RECEIVED
MAR 30 1979
OFFICE OF HEARING
EXAMINERS

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

BEFORE THE MINNESOTA
COMMISSIONER OF HEALTH

In the Matter of Proposed Rules Relating to Crippled Childrens Services Criteria, Procedures and Responsibilities for Eligibility, Cost-Sharing and Reimbursement

AFFIDAVIT OF RECEIPT OF THE SECRETARY OF STATE'S LIST

Nancy Okinow, being first duly sworn upon oath, deposes and says:

1. That she is an employee of the Minnesota Commissioner of Health.

2. That on the 2nd day of March, 1979, she called the Minnesota Secretary of State's office and requested a current list of all representatives of associations or other interested groups or persons who had registered their names with the Secretary of State for the purpose of obtaining notices of public hearings relating to the promulgation of rules or amendments thereto pursuant to Minn. Stat. § 15.0412, subd. 4 (1978).

3. That on the 7th day of March, 1979, in response to the above request, the Secretary of State provided her with such a list, a photocopy of which is attached hereto and incorporated by reference.

Further affiant sayeth not.

Nancy Okinow

Subscribed and sworn to before me
this 19th day of March, 1979.

Marie B. Tromiczak

MARIE B. TROMICZAK
NOTARY PUBLIC - MINNESOTA
HENNEPIN COUNTY
My Commission Expires Oct 9, 1980

STATE OF MINNESOTA
COUNTY OF RAMSEY

CERTIFICATE

In the matter of the Proposed Adoption
of Rules of Minnesota Department of Health Personal Health Services Division
Governing Crippled Children Services Criteria Procedures
and Responsibilities for eligibility, Cost-Sharing and reimbursement

---

I hereby certify that the attached 584 labels 9 sheets constitute the complete list of persons, associations, and other interested groups who as of 8:00 o'clock P.M, this 7th day of March, 1979, have requested pursuant to M.S. 1974, 15.0412, that their names be placed on file with the Secretary of State for the purpose of receiving notice of public hearing on proposed rules on the subject captioned above.

Secretary of State

Joan Anderson Growe

By Donna M. Scott

State # 10

RECEIVED
MAR 30 1979
OFFICE OF HEARING
EXAMINERS

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

In the Matter of Proposed Rules Relating to Crippled Childrens Services Criteria, Procedures and Responsibilities for Eligibility, Cost-Sharing and Reimbursement

AFFIDAVIT OF MAILING

Ward Bisping, being first duly sworn, deposes and says:

That on the 19 th day of March, 1979, at the City of Minneapolis, County of Hennepin, State of Minnesota, he served the attached Notice of Hearing by depositing in the United States mail at said City of Minneapolis, a true and correct copy thereof, properly enveloped, with postage prepaid, to all persons and associations at the addresses listed on the Certificate of the Secretary of State attached and made a part hereof as Exhibit A, to all persons and associations at the addresses listed on Exhibit B, attached and made a part hereof, as well as to all members of the Minnesota Legislature as of the date of mailing.

Ward Bisping

Subscribed and sworn to before
me this 20 day of March, 1979.

Frederick L. King

FREDERICK L. KING
WASHINGTON COUNTY
NOTARY PUBLIC-MINNESOTA
MY COMMISSION EXPIRES FEB. 22, 1984

STATE OF MINNESOTA)
) ss.
COUNTY OF HENNEPIN)

BEFORE THE MINNESOTA
COMMISSIONER OF HEALTH

In the Matter of Proposed Rules
Relating to Crippled Childrens
Services Criteria, Procedures and
Responsibilities for Eligibility,
Cost-Sharing and Reimbursement

AFFIDAVIT OF RECEIPT
OF THE SECRETARY
OF STATE'S LIST

Nancy Okinow, being first duly sworn upon oath, deposes and says:

1. That she is an employee of the Minnesota Commissioner of Health.

2. That on the 2nd day of March, 1979, she called the Minnesota Secretary of State's office and requested a current list of all representatives of associations or other interested groups or persons who had registered their names with the Secretary of State for the purpose of obtaining notices of public hearings relating to the promulgation of rules or amendments thereto pursuant to Minn. Stat. § 15.0412, subd. 4 (1978).

3. That on the 7th day of March, 1979, in response to the above request, the Secretary of State provided her with such a list, a photocopy of which is attached hereto and incorporated by reference.

Further affiant sayeth not.

Nancy Okinow

Subscribed and sworn to before me
this 16th day of March, 1979.

Marie B. Tromiczak

MARIE B. TROMICZAK
NOTARY PUBLIC - MINNESOTA
HENNEPIN COUNTY
My Commission Expires Oct 9 1980

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Minnesota Department of Health Rules Relating to Crippled Childrens Services Criteria, Procedures and Responsibilities for Eligibility, Cost Sharing and Reimbursement

STATEMENT OF EVIDENCE

The Minnesota Commissioner of Health (hereinafter "Commissioner") will introduce the following evidence at the hearing in the above-entitled matter scheduled for Wednesday, April 25, 1979, in St. Cloud, Minnesota, commencing at 9:00 a.m. at the St. Cloud City Hall and on Friday, April 27, 1979, commencing at 9:30 a.m. in Room 105, Minnesota Department of Health Building, 717 Delaware Street Southeast, Minneapolis, Minnesota:

1. Documents evidencing the Commissioner's compliance with procedural requirements for rule making:

(a) Proposed rules;

(b) Proposed Order and Notice for Hearing;

(c) Statement of Number of Persons Expected to Attend and Estimated Length of Time of the Hearing;

(d) Order for Hearing;

(e) Notice of Hearing;

(f) Notice of Hearing as mailed;

(g) Affidavit of Receipt of the Secretary of State's List;

(h) Certificate of the Secretary of State;

(i) Affidavit of Mailing of the Notice of Hearing; and

(j) "Notice of Intent to Obtain Information on Proposed Rules From Non-Agency Sources," as published in the State Register on Monday, December 27, 1976, (1 S.R. 961).

2. Documents attached hereto and made a part hereof constituting the Commissioner's affirmative presentation of facts establishing the need for and reasonableness of the proposed rules and evidencing the Commissioner's compliance with substantive requirements for rule making:

(a) Statement of Need; and

(b) Statement of Facts Establishing Reasonableness of Rules.

3. The following witnesses will represent the Commissioner at the hearing:

Richard Nelson, M.D., Chief, Crippled Childrens Services Unit, Minnesota Department of Health

Grace Gumnit, Assistant Director, Division of Personal Health Services, Minnesota Department of Health

Alpha Adkins, Assistant Chief, Crippled Childrens Services Unit, Minnesota Department of Health

Nancy Okinow, Crippled Childrens Services Unit staff person, Minnesota Department of Health

Said witnesses will be available to answer questions as they might relate to the Commissioner's affirmative presentation of facts as set forth through the previously listed and attached documents.

4. The Statement of Need attached hereto contains the citations to the Commissioner's statutory authority to promulgate the proposed rules.

Dated: March 29, 1979

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

George R. Petterson M.D.

GEORGE R. PETTERSEN, M.D.
Commissioner

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Minnesota Department of Health Rules Relating to Crippled Childrens Services Criteria, Procedures and Responsibilities for Eligibility, Cost Sharing and Reimbursement

STATEMENT OF NEED

The above-captioned rules are new rules of the Commissioner of Health (hereinafter "Commissioner") and address the criteria, procedures and responsibilities relating to services authorized by the Commissioner of Health to help diagnose and treat handicapping conditions in children and those adults with cystic fibrosis or hemophilia.

The need to adopt these rules arises primarily to bring the Department of Health in compliance with existing state and federal legislation concerning reimbursement of services to children and to provide notice of criteria and clarification of procedures to those persons and/or organizations seeking crippled children services and/or reimbursement for these services.

The legal authority for adopting these rules is found in Minn. Stat §§ 144.12, 144.05, 144.07, 144.06, 144.09, 144.010, and 144.11 (1978). Further authority is vested in the Commissioner through Minnesota Department of Administration Reorganization No. 101 issued pursuant to Minn. Stat. § 16.125 (1978) (hereinafter "Reorganization Order 101"). Reorganization Order 101 vests within the Commissioner of Health the authority to implement Minn. Stat. §§ 256.01, subd. 2(3) and (5), 256.011, 257.175, 250.05 and 260.35 (1978) insofar as these statutes concern crippled children services. Further legal authority is found in Minn. Stat. § 15.0412, subd. 1 and 3 (1978).

Minn. Stat. § 144.11 (1978) authorizes the Commissioner to promulgate rules enforcing Minn. Stat. § 144.10 (1978), which relates to federally funded child welfare and public health services. Minn. Stat. § 144.10 (1978) states in relevant part as follows:

> The state treasurer is hereby appointed as the custodian of all moneys received, or which may hereafter be received, by the state by reason of any federal aid granted for maternal and child health welfare service and for public health services, . . . which moneys shall be expended in accordance with the purposes expressed in the acts of congress granting such aid and solely in accordance with plans to be prepared by the state commissioner. . . . Such plans shall be designated to secure for the state the maximum amount of federal aid which is possible to be secured on the basis of the available state, county and local appropriations for such purposes.

The State of Minnesota has received federal moneys for maternal and child welfare services and public health services pursuant to 42 USCA §§ 701-703, 705-713 (1974) (also referred to as Title V of the Social Security Act, enacted August 14, 1935, Ch. 531, Title V, 49 Stat. 629 and amended thereafter) and the regulations promulgated thereunder, 42 CFR §§ 51a.101-51a.143. More specifically, the Minnesota Department of Health is the state agency as described in 42 CFR §§ 51a.101 to administer and supervise the administration of a state plan for maternal and child health, which plan provides among other things services to children with handicaps. The Minnesota Department of Health developed a maternal and child health state plan which includes provision for services to children with handicapping conditions. In 1975, the United States Government accepted the Minnesota plan, and it has accordingly been transferring moneys to the State of Minnesota to carry out this plan.

Thus, the Minnesota Department of Health, as an agency of the State, has received and expended federal moneys in accordance with the purposes expressed in acts of Congress granting such aid and in accordance with plans prepared by the Department of Health. Minn. Stat. § 144.11 (1978) states as follows:

> The Commissioner may make such reasonable rules and regulations as may be necessary to carry into effect the provisions of section 144.10 and alter, amend, suspend or repeal any such rules and regulations.

These rules are proposed in order to expend United States moneys needed by the State in accordance with 42 USCA § 701-703, 705-713 (1974) and to promulgate into all those parts of the state plan which affect the rights of the public.

Minn. Stat. § 144.05 (1978) states in relevant part as follows:

> The state commissioner of health shall have general authority as the state's official health agency and shall be responsible for the development and maintenance of an organized system of programs and services for protecting, maintaining and improving the health of the citizens. This authority shall include but not be limited to the following:
>
> (b) Plan, facilitate, coordinate, provide, and support the organization of services for the prevention and control of illness and disease and the limitation of disabilities resulting therefrom;
>
> (c) Establish and enforce health standards for the protection and the promotion of the public's health . . .;
>
> (f) Coordinate and integrate local, state and federal programs and services affecting the public's health;
>
> . . . .

The rule making authority conferred upon the Commissioner to exercise this authority is found in Minn. Stat. § 144.12 (1978) which states in relevant part as follows:

> 1. The commissioner may adopt, alter, and enforce reasonable regulations of permanent application throughout the whole or any portion of the state, or for specified periods in parts thereof, for the preservation of the public health.

The proposed rules are needed to preserve the public health inasmuch as the purpose of the rules is to facilitate the provision of services to children with handicapping conditions and to provide quality assurance for such services. By providing crippled childrens services, health care may be given to children who may not now be receiving it. The Crippled Childrens Services program helps accomplish this goal by identifying children with health problems or needs that may not have been recognized or have not been fully cared for, and by insuring that these problems are adequately referred to others for further diagnosis and treatment.

A child with a handicapping condition may fail to receive needed health care for any or a combination of the following reasons:

1. Because the problem can be detected only by special tests or observations;

2. Because the health importance of a problem or symptom is not recognized by the parents or guardians of the child;

3. Because appropriate health care has not been sought for a recognized problem;

4. Because needed preventative services have not been used;

5. Because the parents or guardians of the child are unaware of referral sources within the community area or elsewhere.

A strategy for preserving the public health of children and those individuals with cystic fibrosis or hemophilia is to discover unmet health needs by providing diagnostic evaluations. The diagnostic evaluations as outlined in the rules are designed to determine whether a child is at health risk and, therefore, in need of further referral and/or treatment. By this strategy, scarce resources for diagnostic evaluation and futher treatment are concentrated on those children who most need them. In the last year, 6,900 children were served in field clinics established by the Department of Health periodically throughout the state to diagnostically evaluate children with handicapping conditions. Seven thousand children were referred by the Department of Health to medical centers for treatment under the currently existing program. These children require specialized, and in many instances, costly care and services related to their conditions. Such care and services are not evenly distributed around the state. Thus, the program in the rules implementing the program exists to assure that handicapped children obtain necessary care and treatment through the provision and, if necessary, reimbursement of, services by appropriate resources.

Furthermore, these rules are necessary to provide a minimal degree of uniformity to applicants and eligible individuals consistent with efficient operation and qualitative standards. These rules are also designed to prevent wasteful duplication as well as possible fragmentation among different programs throughout the state.

Reorganization No. 101 clearly confers upon the Department of Health the authority and duties relating to noninstitutional services to Crippled Childrens Services recipients and administration of federal funds for children eligible for these services under Minn. Stat. § 256.01, subd. 2(3) and (5). Reorganization Order No. 101 also addresses the Commissioner's authority to accept and administer

federal grants in aid to Crippled Childrens Services, the responsibility for promoting public awareness of laws protecting crippled children eligible for these services, the authority to administer the state appropriation to the Gillette Hospital Authority for crippled childrens services and the authority to arrange for tests for the diagnosis, treatment and care of children eligible for crippled childrens services pursuant to Minn. Stat. §§ 256.011, 257.175, 250.05 and 260.35 (1978).

The authority of the Commissioner with regard to services and reimbursement for services provided to those with cystic fibrosis is found in Minn. Stat. § 144.156 (1978); to those with hemophilia is is found in Minn. Laws 1977, ch. 453, § 24.

Finally, authority and need for these rules are found in Minn. Stat. § 15.0412, subd. 3 (1978). Subdivision 1 of the statute requires that each agency adopt rules consistent with its duties and obligations. "Except as provided in subdivision 3 . . .", the law states that the Administrative Procedure Act itself does not constitute authority for an agency to adopt rules. Subdivision 3 states as follows:

> Each agency shall adopt rules setting forth the nature and requirements of all formal and informal procedures related to the administration of official agency duties to the extent that those procedures directly affect the rights of or procedures available to the public.

The rights of applicants seeking eligibility for diagnostic evaluation, applicants seeking eligibility for treatment services, applicants seeking either cost-sharing or reimbursement and the rights of service providers are affected by the approval or nonapproval of their applicants by the Commissioner of Health. Surely, applicants for these services and/or funds are entitled to notice as to what procedures shall be used with regard to receiving the same. Applicants are entitled to advance knowledge of the standards and criteria upon which their application shall be reviewed as well as the standards and procedures upon which they may continue to be approved. These rules are necessary so as to preclude the possibility of conferring too wide a path of bureaucratic discretion upon state decision-makers. Inasmuch as the administration of services to persons with handicapping conditions

is an official duty of the Commissioner pursuant to those statutes referenced above, these rules are necessary to set forth the nature of his requirements and procedures with respect to the provision of services. It is necessary to ensure that the Commissioner and those acting under his authority concentrate their reviewing efforts to those items within these rules which relate to the ultimate public health benefits of providing services to children with handicapping conditions and which are within their expertise to review.

Further need is clarified and put forth in the Statement of Facts establishing reasonableness of the rule.

Dated: March 29, 1979

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

George R. Pettersen M.D.

GEORGE R. PETTERSEN, M.D.
Commissioner

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of the Minnesota Department of Health Rules Relating to Crippled Childrens Services Criteria, Procedures and Responsibilities for Eligibility, Cost Sharing and Reimbursement

STATEMENT OF FACTS ESTABLISHING REASONABLESS OF RULES

The Minnesota Commissioner of Health (hereinafter "Commissioner"), pursuant to Minn. Stat. § 15.0412, subd. 4 (1978), hereby affirmatively presents facts establishing the reasonableness and justifying the adoption of the above-captioned rules in the document entitled "Justification" attached hereto and made a part hereof. The need and statutory authority for the proposed rules is set forth in the Statement of Need. [Terms used throughout this Statement will have the definitions given them in proposed 7 MCAR § 1.651 B.]

Dated: March 29, 1979

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

George R. Petersen M.D.

GEORGE R. PETTERSEN, M.D.
Commissioner

STATEM[redacted] OF NEED RELATING TO PROPOSED [redacted]LES
OF MINNESOTA DEPARTMENT OF HEALTH
CRIPPLED CHILDREN SERVICES PROGRAM

Chapter Thirty-One: 7 MCAR §§ 1.651 - 1.657

7 MCAR § 1.651 GENERAL

7 MCAR § 1.651 A. provides an introductory explanation to the purposes of these rules. The subjects, discussed below, are needed to give the reader precise knowledge of the Crippled Children Services (CCS) criteria, procedures, and responsibilities related to applicant eligibility, applicant cost-sharing, and reimbursement to service providers for service(s) authorized by CCS for physically handicapping conditions in children.

The statutory authority to promulgate and adopt these rules is contained in Minnesota Statute §§ 144.05, 144.06, 144.07, 144.09, 144.10, 144.11, 144.12 (1978) and under State of Minnesota, Department of Administration Reorganization No. 101 pursuant to Minnesota Statute § 16.125 (1978). Further authority to implement these rules is found in Minnesota Statute §§ 256.01, Subd. 2(3) and (5), 256.011, 257.175, 250.05, subd. 6, 250.35, and 15.0412 (1978)

CCS is a statewide program providing diagnostic evaluations and reimbursement to service providers for the costs of treatment of children with physically handicapping conditions. Therefore, these Rules apply to those individuals with physically handicapping conditions and to those service providers (individual or institutional) who provide service(s) to CCS eligible individuals.

7 MCAR § 1.651 B. provides definitions to thirty separate terms used in the Rules. The definitional provisions, discussed individually below, are necessary to effect a uniform interpretation of the Rules and to avoid uncertainty and ambiguity in dealing with the Rules.

1. Adjusted Gross Income

This definition is needed to clarify those portions of the Rules that relate to applicant cost-sharing procedures. The adjusted gross income figure, as stated on the federal IRS form, constitutes the statement of an applicant's income for the year and the income level at which CCS applies cost-sharing calculations. The adjusted gross income figure can be verified for those who have filed an IRS tax form. This figure allows for an equitable manner of determining an applicant's total income figure for the year.

2. Administrative Review Committee

This definition is needed to clarify those portions of the Rules relating to the administrative review process. The term defines the makeup of the committee and specifies the role of this committee so as to assure consumers fair and equitable application of these Rules.

3. Allowable Deductions

This definition is needed to detail the items that applicants will be allowed to deduct from their adjusted gross income figure. This definition makes clear the fact that these deductions are not necessarily the same as those

allowed by IRS in the statement of federal adjusted gross income. Applicants who have had special expenditures related to the cost of medical treatment will be given credit for these expenditures as they affect the amount of income an applicant has at his/her disposal.

4. Applicant

This definition is needed to clarify those portions of the Rules which make reference to the "applicant". It refers to both the child, parents (or legal guardians of a child), or the adult individual requesting services. The use of this term to refer to all of these individuals reduces the volume of wording and provides clarity and ease of understanding for the reader.

5. Application

This definition is needed to clarify those portions of the Rules which make reference to the application procedures. The application contains information that is considered to be basic and essential to the determination of an applicant's eligibility and type of services required. Requirements that information be submitted in a specified format provides for uniformity and completeness. A specified format allows the collection of comparable information that is consistent for all applicants.

6. Authorization Form

This definition clarifies those portions of the Rules relating to the authorization of service(s) for reimbursement by CCS. This standard document helps the parties, including vendors, parents, patients, and CCS to have a clear and continuing understanding of expectations in relation to the service(s) requested and how payment for the service(s) will be handled.

7. Child with a Handicap

This definition is essential for the CCS Program and these Rules as it is one of the definitive criteria for eligibility for the service(s) provided by CCS. This definition provides the public with guidance as to the way in which a handicap is defined by the CCS Program. The Social Security Act, as amended, Title V (USC 42, Chapter 7) and federal regulations (42 CFR Part A s 51a.101), which govern the Program, require the identification of children in need of health care and services. In order to facilitate this identification, the definition is broad so as not to unnecessarily limit the population of children who would be eligible and could benefit from a complete diagnostic evaluation and possible treatment services.

8. CCS

This definition is necessary as it provides a shorthand reference to the Crippled Children Services Program.

9. CCS Adjusted Income

This definition is necessary to clarify those portions of the Rules which make reference to cost-sharing and cost-sharing procedures. This definition

differentiates between the adjusted gross income figure and the CCS adjusted income figure. The CCS adjusted income accounts for any assets a family or individual may have and/or deductions that may affect their ability to share in the costs of treatment.

10. Comprehensive Care Center

This definition is necessary to clarify the type of facility that is to be used for the evaluation and treatment of hemophiliacs. The bleeding tendency of hemophiliacs can make almost any type of care or treatment, e.g., dental care and surgery, hazardous. Because of this fact, an organized multi-disciplinary team, specialized in the care and treatment of hemophiliacs, is necessary to provide safe and quality care.

11. Cost-sharing

This definition relates specifically to those portions of the Rules which explain the principle and procedures related to cost-sharing. This definition identifies the method by which families or individuals, who are able, pay a part of the cost toward treatment services. The definition is necessary to specify that cost-sharing is directly related to the individual's ability to pay and that the method is standardized and equitably applied.

12. Cost-sharing Schedule

This definition is necessary as it establishes the income levels and percentages for determining the amount, if any, an applicant will share in the cost of treatment services. This schedule accounts for the effect that income level and household size can have on the ability of an applicant to pay a portion of the treatment costs. The basis for the development of this fee schedule is provided by the Social Security Act, as amended, Title XX, as well as the Consumer Price Index and national budget surveys.

13. Diagnostic Evaluation

This definition clarifies what a diagnostic evaluation entails for the purposes of these Rules. Complete and definitive diagnosis is an important function of the CCS Program. Determining a plan of treatment related to the child's condition is a vital component in securing such care for the child. Many of the children referred to the CCS Program have multiple and complicated conditions which make it reasonable to require that a specialized multidiscplinary approach be used to evaluate the condition of the individual child.

14. Federal Act

This definition is needed as it allows a shorthand reference to the Social Security Act, as amended, Title V, USC 42, which specifies regulations and authorizes federal formula funding for the CCS Program.

15. Hemophilia

This definition is necessary to describe the specific population eligible for reimbursement for specified services under Minnesota Laws 1977, Chap. 453, Section 24.

16. Household Member

This definition clarifies those portions of the Rules that relate to cost-sharing procedures. The definition goes beyond the notion that to be considered a household member the individual must physically reside in the same house. The size of a household is one of the factors used in determining the amount that an applicant will be required to cost-share. The principle of cost-sharing is based on the ability of an applicant to pay. Although an individual may not physically reside in the house, the family may still be financially responsible for him and this factor needs to be taken into consideration.

17. Household Member Deduction

This definition is necessary to clarify those portions of the Rules which relate to cost-sharing procedures and to describe a specific deduction that is only deducted from the total of the includable assets. This deductable amount is an average to allow for the added per person costs of maintaining members of a household.

18. Includable Assets

This definition is necessary to clarify those portions of the Rules which relate to cost-sharing and cost-sharing procedures. Assets, as used in this definition, refer to specific types of resources belonging to an individual which may realistically be used in payment of debts. CCS has chosen to include only those assets which are readily convertible to cash. Business or property assets have not been included.

19. Long-term Physically Handicapping Condition

This definition is necessary to clarify those portions of the Rules which relate to eligibility for CCS treatment services. A long-term physically handicapping condition is the definitive criteria for determining eligibility for CCS reimbursement to service providers for the cost of treatment services. In general, the long-term conditions are more complicated medically, costly and have severe impact on the child's growth, development and future employability. The CCS multi-disciplinary staff is designed to serve the needs of children with these types of conditions. The funds available for treatment services are limited. Therefore, to maximize program capability and provide needed financial assistance to those families or individuals where the expense may be great, the treatment dollars are used to treat and rehabilitate long-term conditions.

20. Medical Director

This definition is needed to designate the individual responsible for the administration and management of the CCS Program.

21. One-person Household

This definition is needed to clarify those portions of the Rules which relate to cost-sharing and the cost-sharing procedures. This definition is needed to specify the various situations in which an individual may be living with others and yet be considered a household of one for the purposes of determining the amount of cost-sharing. Household size is a factor in determining cost-sharing. This definition clarifies the fact that only the parents or legal guardians are liable for cost of care where the applicant is not self-supporting.

22. Prior Authorization

This definition is necessary to clarify those portions of the Rules relating to reimbursement for service(s) and to denote the principle that before the cost of services will be reimbursed by CCS, they must be authorized in advance. The federal regulations (42 CFR Part A § 51a.111) governing the CCS Program require that services be authorized by an agent of CCS prior to the services being provided. Prior authorization helps to assure fiscal accountability for the Program and provides all parties with an understanding of the expectations related to the services and method of payment.

23. Reimbursement

This definition is needed to clarify those portions of the Rules relating to payment by CCS for the costs of services. As used in these Rules, this term refers only to those instances where CCS will reimburse providers for all or partial costs of services to CCS eligible children.

24. Self-supporting Individual

This definition is needed to clarify those portions of Rules which relate to cost-sharing and the number of members in the household. This definition is consistent with the one used and accepted by the IRS as constituting a self-supporting individual.

25. Service Provider

This definition is needed to clarify portions of these Rules related to reimbursement for service(s) and to specify the individuals, groups, or institutions who provide the kinds of services needed to correct or ameliorate the handicapping conditions of the children that CCS encounters. This definition also clarifies the fact that a provider must meet certain quality assurance standards as specified in these Rules in order to be eligible to participate in the CCS Program.

26. State Gross Median Income

This definition relates to cost-sharing and cost-sharing procedures. The state gross median income, as calculated for each household size by the Minnesota Department of Employment Services, is the basis for establishing

the levels on the CCS cost-sharing schedule. Applicants whose CCS adjusted income is above 60% of the state gross median income are required to share in the cost of treatment. This starting point is the same as that used by the Title XX Program. Research on the subject of cost of living has shown that this 60% level is consistent with the income levels determined by the Consumer Price Index and national budget surveys to be those at which a family has some discretionary income over and above what is needed for the necessities of living.

27. Third-party Reimbursement Sources

This definition is necessary to clarify those portions of the Rules relating to reimbursement for service(s) and to describe the payment mechanisms other than payment by the applicant or CCS that can be used to pay the full or partial cost of services authorized for eligible individuals.

28. Title XIX (Medical Assistance)

This definition is necessary to clarify portions of these Rules relating to reimbursement and to identify the federal program and the source of payment for the costs of evaluation and treatment (medical care) for those individuals defined under 42 USC, Title XIX 1901-1910 (Social Security Act as amended) who are eligible for such payment. By federal regulation, Title XIX is obliged to pay for costs of care of eligible children before Title V USC 42, Chapter 7 funds may be used.

29. Treatment Service(s)

This definition is necessary in order to delineate the wide range of services which may be authorized by CCS relative to a child's handicapping condition if determined eligible.

30. Treatment Plan

This definition is necessary to clarify those portions of the Rules which relate to the authorization for reimbursement by CCS of treatment services. This definition describes what constitutes a treatment plan and who will be responsible for the development of it. The children to whom the CCS Program provides service generally have a constellation of needs. The development of a treatment plan is a method of assuring that the handicapped individual receives services tailored to the individual needs of that person. The treatment plan also allows the CCS Program to evaluate the appropriateness and effectiveness of such services.

7 MCAR § 1.692 APPLICANT ELIGIBILITY FOR DIAGNOSTIC EVALUATION

This section of the Rules establishes the individual eligibility criteria for a diagnostic evaluation by CCS. This information gives the reader specific knowledge as to who will be eligible for CCS service(s). It is reasonable to require that any individual wishing to be considered for CCS service(s) must make formal application in order that CCS may document the basis for eligibility. Income is not a criteria of eligibility for diagnostic evaluations. The federal regulations

42 CFR Part A § 51a.109 governing the CCS Program require that diagnostic services be made available to children and their families without charge other than the use of third-party payments. The intent of the Program is the early identification of children in need of health care and the diagnosis and evaluation of the condition of such children. The fact that income is not a criteria for eligibility allows CCS to reach a larger group of children for diagnostic purposes.

7 MCAR § 1.652 A. 1. CCS is a statewide program. Established residency within the state is the only geographic limitation. No specific length of residency is required. Children of migrant workers are considered residents for the period of seasonal employment.

7 MCAR § 1.652 A. 2. states that an applicant must be under 21 years of age with the exception of those individuals 21 years or over with cystic fibrosis or hemophilia. The federal regulations (42 CFR Part A § 51a.101) governing the CCS Program define a child with a handicap as an individual below the age of 21, thus setting the upper age limit for the provision of services. State funds are used as matching funds and subject to the same definition. The only exceptions to this age limit result from the following state statutes and laws administered by the Minnesota Department of Health: Minnesota Statute 1974, Chapter 144, Subd. 146 appropriated state funds for the medical care and treatment of persons over 21 suffering from cystic fibrosis. Minnesota Laws 1977, Chapter 453, Section 24 appropriated state funds for the care and treatment of persons over 21 suffering from hemophilia on a priority basis. Therefore, it is reasonable to specify the age limitations as stated.

7 MCAR § 1.652 A. 3. states that an applicant shall be a child who is suspected to be a child with a handicap. For the purposes of these Rules, child with a handicap is broadly defined, making many children eligible to receive a diagnostic evaluation. Nevertheless, CCS has limited funds and does not function as a primary health service for well children. The diagnostic services are primarily intended for those children where there is realistic suspicion of a condition or problem that exists which might hinder normal growth and development, as determined by review of the completed application.

7 MCAR § 1.652 B. This section is necessary and reasonable in order to specify two procedural requirements which are intended to maximize the use of available state and federal funds and are required by federal regulations (42 CFR Part A § 51a.109, 111) for use of the federal funds.

7 MCAR § 1.652 B. 1. states that although there shall be no out-of-pocket costs to an applicant, they shall be required to make use of available third-party reimbursement sources for any examinations and tests that may be necessary to the diagnostic process. CCS asks that where third-party payments are available, they be used in order to conserve the limited funds of the Program. Where no third-parties exist or where third-party funds are not sufficient to cover the costs, families are not required to pay anything out-of-pocket for the cost of a diagnostic evaluation.

7 MCAR § 1.652 B.2. states that prior written authorization shall be required for a diagnostic evaluation to be reimbursed in full or in part by CCS. It is necessary and reasonable for CCS to prior authorize in order to insure fiscal accountability, coordination, and timeliness of services and to allow all the parties involved, including parents, providers, patients, and CCS, to have a clear understanding of expectations and obligations in relation to what service is to be provided and how payment will be handled. Prior authorization also provides a safeguard against the inappropriate and ineffective use of services.

7 MCAR § 1.653 APPLICANT ELIGIBILITY FOR TREATMENT SERVICES

This section sets forth the criteria and requirements relating to an applicant's eligibility for reimbursement for the costs of treatment service(s). The information is necessary to give the applicant specific knowledge as to who will be eligible for reimbursement by CCS of the costs of treatment service(s).

7 MCAR § 1.653 A. It is necessary and reasonable that applicants complete a standard application so that CCS may make an equitable review and determination as to an individual's eligibility for treatment services. The complete application allows CCS to collect comparable information on each applicant and to document the basis for an applicant's eligibility.

7 MCAR § 1.653 A. 1. CCS is a statewide program. It is reasonable that established residency within the state is the only geographic limitation. No specific length of residence is required; children of migrant workers are considered residents for the period of seasonal employment.

7 MCAR § 1.653 A. 2. It is necessary and reasonable that an applicant must be under 21 years of age with the exception of those adults 21 years or over with cystic fibrosis or hemophilia. The federal regulations (42 CFR Part A § 51a.101) governing the CCS Program define a child with a handicap as an individual below the age of 21, thus setting the upper age limit to the provision of services. State funds are used as matching funds and thus subject to the same definition.

Inclusion of the two specific adult populations is due to M.S. 1974, Chap. 144, Subd. 146, and Minnesota Laws 1977, Chap. 453, Section 24, which specifically appropriated funds for the care and treatment of persons over 21 with cystic fibrosis or hemophilia. CCS has responsibility for the administration and management of these programs.

7 MCAR § 1.653 A. 3. This section is necessary and reasonable to specify the criteria that the child must have a diagnosed long-term physically handicapping condition in order to be eligible for CCS reimbursement to service providers for the cost of treatment. In general, long-term conditions are more complicated medically, costly and have severe impact on the child's growth, development and future ability to function. In order to maximize the limited funds available

for the treatment portion of the Program and provide needed financial assistance to those families or individuals where the expense is great, CCS gives priority to long-term physically handicapping conditions. The CCS Program is especially structured to meet the needs of children with complicated long-term physically handicapping conditions. There is no other state resource to provide similar services.

7 MCAR § 1.653 B. This section is necessary and reasonable in order to specify three procedural requirements which relate to CCS eligibility for treatment services and which allow the efficient and equitable application of CCS program resources.

7 MCAR § 1.653 B. 1. It is reasonable to require families, who are able, to share in paying the costs of treatment services. This cost-sharing is established on the basis of an applicant's ability to pay and takes into account individual factors which may impinge on this ability. Cost-sharing permits CCS to maximize the limited treatment resources and serve a larger segment of the population in this way. It is necessary that a family or individual make a formal commitment to assume partial responsibility for the costs of care.

7 MCAR § 1.653 B. 2. It is necessary and reasonable to expect that families shall make use of available third-party reimbursement resources where they are available. The use of these payment mechanisms further permits CCS to maximize limited treatment funds. In this way, treatment dollars may be available for a larger number of families and for those who are unable to pay for the cost of treatment or who have no third-party resources. The federal regulations (42 CFR Part A § 51a.109) require that all third-party resources be used prior to applying Title V (USC 42, Chapter 7) resources to paying for treatment.

7 MCAR § 1.653 B. 3. It is necessary and reasonable to require that treatment services, which are to be reimbursed in part or in full by CCS, be authorized by CCS prior to the provision of such service. The federal regulations (42 CFR Part A § 51a.111) require such prior authorization for reasons of fiscal accountability and to provide the parties involved with a clear understanding of expectations and obligations involved regarding services provided and conditions of payment. The notion of prior authorization allows CCS to evaluate the necessity and timeliness of services and safeguards against the inappropriate use of services.

7 MCAR § 1.653 C. It is reasonable to provide an exception to the criteria that all eligible physically handicapping conditions must be of a long-term nature. This one exception recognizes that although some conditions such as Respiratory Distress Syndrome may be corrected or significantly ameliorated in a short period of time or with a one time only treatment procedures, the cost of treatment for certain corrective conditions can be prohibitive for a family or individual. The intent of this exception is to provide such people with help in covering the costs of such treatment. The average family can be severly financially disabled by a single medical/surgical event which requires more than 40% of their adjusted gross income.

7 MCAR § 1.654 APPLICATION AND COST-SHARING FOR APPLICANT(S)

This section of the Rules is reasonable and necessary to set forth procedures and information directly related to the application process. The specific procedures for determining an applicant's cost-sharing ability and an applicant's responsibilities in relation to cost-sharing are set forth in this section.

7 MCAR § 1.654 A. 1. is necessary to clarify that anyone desiring services from CCS may request an application and apply for services. The signed statement by the applicant is necessary to offer CCS assurance that the information furnished in the application is true and complete to the best of an applicant's ability.

7 MCAR § 1.654 A. 2. is necessary and reasonable to set a time frame in order to insure orderly and timely processing in the review of applications. Based upon the past experience of CCS in processing applications, the 30-day limit is reasonable and is necessary as it allows sufficient time for CCS to gather any additional information that may be needed to thoroughly make the medical and financial determinations. It is necessary to specify what the review of an application entails so that an applicant will be aware of all procedures.

7 MCAR § 1.654 A. 3. is reasponable and necessary so that an applicant will know the status of their application and be fully informed as to any decisions concerning eligibility for reimbursement. This section is necessary to comply with concepts of fundamental fairness. Written notification is needed so that both CCS and the applicant have documented evidence of the action taken.

7 MCAR § 1.654 A. 4. It is reasonable and necessary that those applicants who are determined capable of paying a share of the treatment costs shall be required to sign the cost-sharing agreement before CCS will authorize any services. Cost-sharing is a requirement for eligibility when determination as described in (B) of this section indicates they are capable of paying a share of costs. Applicants are not required to sign an agreement unless they wish to have CCS help them with the cost of treatment. The cost-sharing agreement constitutes a contract and is evidence that the applicant knows and understands what financial obligations they will incur. It also constitutes insurance for CCS that the applicant will assume these financial obligations.

7 MCAR § 1.654 A. 5. is necessary and reasonable to take into consideration the fact that circumstances surrounding a particular handicapping condition may change. What may have once been considered a short-term problem could, due to complications or unresponsiveness to a particular course of treatment, now require lengthy care. The intent of this statement is to encourage applicants to again seek help from CCS when they feel there has been a change in their situation. Applicants are not determined permanently ineligible.

7 MCAR § 1.654 A. 6. is necessary to give applicants a definite time period in which they will remain eligible. This section recognizes that the point at which eligibility begins will vary for applicants depending on the circumstances surrounding their application. The length of eligibility will be 12 months in all instances. The only difference is the point at which it starts. The CCS Program and individual applicants need to know the period of eligibility so that they can plan financial affairs. It is also necessary so that no gap exists in the reapplication process.

7 MCAR § 1.654 A. 6. a. b. states the point at which eligibility begins for those applicants who apply through routine channels. In these instances, it is reasonable to expect the normal processing of the application will occur. Applicants have to have firmly in mind when eligibility begins so that expectations and obligations are clearly understood.

7 MCAR § 1.654 A. 6. c. is necessary and reasonable in that it recognizes that, in certain instances, applicants who may need CCS assistance would be penalized by the normal processing of their applications. In a few cases, applicants may already be involved in a treatment situation when they become aware of CCS. Not providing treatment or the delay of treatment could be contrary to good medical practice. If individuals in this group of applicants complete and return the application in a timely manner and they are determined eligible, CCS will retroactively establish eligibility from the point of the applicant's initial contact with CCS. Because this is an exception to the general policy, it is reasonable to require documentation to be considered an exception.

7 MCAR § 1.654 A. 7. is necessary and reasonable so there is no misunderstanding with regard to the beginning date of an applicant's eligibility.

7 MCAR § 1.654 A. 8. is necessary and reasonable in that individual and family circumstances change and eligibility must be reevaluated periodically to determine if an individual still meets the criteria as specified in these Rules. It is reasonable that an annual review be established. It is necessary to complete a new application to assure equitable and standard review of each application.

7 MCAR § 1.654 B. This section of the Rules is necessary to set forth the principles, procedures, and information governing cost-sharing. The methods for determining the amount of an applicant's cost-sharing are specified as is the actual cost-sharing schedule. It is necessary that applicants be aware of these procedures in order to understand how CCS services apply to them and what obligations applicants may be required to assume.

7 MCAR § 1.654 B. 1. This section is necessary to establish the point at which an applicant will be required to begin sharing in the costs of treatment. Cost-sharing amounts are based on an individual's ability to pay. The level established by CCS to determine the point at which cost-sharing begins is consistent with other state programs, such as the Social Security Act, as amended Title XX, which

require applicants to share in the costs of services. It is also based on national and state surveys ("Consumer Price Index" and "Urban Family Budgets and Comparative Indexes" published by the U.S. Department of Labor in 1977) which determine how much it costs a family to maintain a certain standard of living. Below 60% of the state gross median income by family size, as evidenced in the cited sources, it has been determined that a family probably uses all of its income for necessities, food, clothing, and shelter. Above this 60% point, it is assumed that a family begins to have some discretionary income and can be expected to share in the costs of treatment without sacrificing necessities of living.

Cost-sharing allows CCS to extend its limited treatment funds so that some aid is available to a larger segment of the eligible population than might otherwise be possible. Long-term handicapping conditions have a severe, negative impact on families regardless of income level. CCS tries to be a resource to the extent possible to these families.

It is reasonable for CCS to assure reimbursement to providers where treatment has been authorized, for the remaining expenses, up to the Title XIX rates, which is the payment schedule acceptable to CCS.

7 MCAR § 1.654 B. 2. This section is necessary and reasonable to specifically name those groups of individuals who will not be required to share in the treatment costs. Applicants in these categories have incomes known to be below a level at which they would be expected to share costs, or they are eligible for reimbursement of the costs of care through other known governmental aid programs.

7 MCAR § 1.654 B. 3. It is necessary and reasonable that an applicant know whose income will be counted in any cost-sharing determinations. Only the income of the parent or legal guardian who is financially responsible will be used. Relatives or individuals who have no legal financial responsibility are not liable for the costs of care. It is reasonable to only look at the income of those individuals with legal responsibility for the care of the child. CCS does not expect other relatives who do not have such legal responsibility to assume payment for the cost of care.

7 MCAR § 1.654 B. 4. This section is necessary to set forth the steps involved in the actual determination of an applicant's cost-sharing, so that applicants will be informed and aware of the procedures involved, the factors upon which a determination is based and that the procedures can be equitably applied to all.

The formula used by CCS to calculate cost-sharing accounts for those medical expenses not covered by insurance and paid by the family, assets, and the number of members in the household, all of which may have a direct bearing on an applicant's ability to share in the costs of treatment.

Therefore, the CCS adjusted income figure, derived after completing cost-sharing calculations, is a more accurate reflection of an applicant's income level and provides a more equitable base from which to figure the percentage the applicant shall pay toward the cost of treatment.

The cost-sharing schedule is necessary as it indicates the income levels by number of members in the household and the corresponding percentages an applicant shall be required to pay. It is reasonable to provide a schedule in this format to assure equitable and standard utilization. The basis for the development of this schedule is provided by the Social Security Act, as amended Title XX, as well as the Consumer Price Index and national budget surveys cited in 7 MCAR § 1.654 (B)(1).

7 MCAR § 1.654 B. 5. This section of the Rules is necessary in that it establishes, and makes known, the criteria upon which CCS will make decisions with respect to adjustments in an applicant's cost-sharing.

7 MCAR § 1.654 B. 5. a.b.c. It is reasonable that the specific criteria were established at the points at which a change of at least that degree is necessary to have a noticeable effect on an applicant's capacity to share in the costs of treatment. For example, small changes either way in the income level of an applicant would not have any marked effect on the cost-sharing level.

7 MCAR § 1.654 B. 5. d. recognizes that some families will incur large costs for travel, lodging, and child care related to the treatment of their child. Complicated conditions may require specialized care at a medical center on a frequent basis or prolonged stays in and near the center. Some families will have to travel long distances to get to these centers, e.g., Mayo, University Hospital, and the length of stay may amount to several weeks. These expenses are not the direct medical costs of treatment but occur as a result of the child's treatment plan.

It is reasonable that CCS may make an exception in these situations and allow an adjustment in cost-sharing. It is reasonable to acknowledge that for some families these costs may create a financial burden and make it extremely difficult or impossible to assume the cost-sharing required of them. It is, therefore, reasonable to make provision for review of these special circumstances with the intent to lower the cost-sharing appropriately.

7 MCAR § 1.654 B. 6. This section is necessary and reasonable to establish and make clear the applicant's responsibility for reporting changes in his/her household size or income level and states CCS action in the event that an applicant does not report changes which might alter their ability to share costs of treatment.

7 MCAR § 1.654 B. 7. This section is necessary and reasonable so that applicants are aware of their limited liability for cost-sharing. Although some families may have two or more children with handicapping conditions, it is reasonable to maintain a single cost-sharing level for an entire household. To do otherwise might be considered unfair to a household which happens to have two or more eligible children. A family who has more than one child with a handicapping condition will have a greater financial and emotional burden and a diminished capacity to handle the financial obligations of treatment costs.

7 MCAR § 1.655 REIMBURSEMENT FOR SERVICE(S)

This section of the Rules is necessary to specify conditions related to the authorizations for reimbursement of services by CCS and the limitations on such authorizations.

7 MCAR § 1.655 A. The federal regulations (42 CFR, Part A, 51a.111) require CCS to prior authorize for diagnostic evaluation and treatment services. It is necessary and reasonable that the format of the authorization be designated by CCS to assure uniformity. The authorization form details what service(s) is to be provided and the conditions of payment. This form is consistent with federal and state program and fiscal requirements, which do not allow the transfer of monies until such payments are authorized. The authorization form provides a method to assure the proper disbursement and accounting for funds paid to CCS under these federal regulations.

7 MCAR § 1.655 B. It is reasonable to anticipate that there are emergency situations which cannot be authorized before the service is provided. This section is necessary in order to specify the criteria that CCS will use in determining what is an emergency. It is reasonable and necessary to impose a time constraint for the notification of CCS by a hospital that an emergency has occurred and to limit the amount of time for which CCS will maintain liability. This time constraint impresses upon the reporter the urgency of letting CCS know immediately, gets the application process going, and cuts down on possible fraud. Eligibility beyond this point is based on the previously specified criteria in these Rules.

7 MCAR § 1.655 C. is necessary to set forth the limitations on authorization of reimbursement for treatment services so as to insure that expectations conform to reality.

7 MCAR § 1.655 C. 1. It is reasonable to anticipate that many of the children known to CCS have complicated conditions and need involved, specialized care. A treatment plan allows for a coordinated approach to the care of these problems. The treatment plan also assures that services are related only to the condition for which the child is eligible. CCS funds are limited and not intended for general medical care purposes. It is reasonable and necessary to specify this limitation.

7 MCAR § 1.655 C. 2. It is reasonable that treatment services be reimbursed by CCS when they offer hope of improving the individual's functional or developmental status. Limited funds necessitate that they be used where the most significant improvement in a child's functioning can be obtained. It is, therefore, necessary and reasonable that services which are mostly cosmetic in nature not be authorized for reimbursement by this Program.

7 MCAR § 1.655 C. 3. It is reasonable and necessary that CCS does not reimburse for the costs of equipment when such equipment is not therapeutically related to the individual's handicapping condition. Equipment such as hospital beds and wheelchairs is generally needed for the maintenance of an individual rather than something which is of a rehabilitative nature. This restriction is due to the limited funds and the necessity to establish priority.

7 MCAR § 1.655 C. 4. CCS has limited funds available for treatment services based upon the federal formula contained in 42 CFR, Part A § 51a.123 and legislative appropriation. In an effort to provide some financial aid with the costs of treatment to a larger group of individuals, it is necessary and reasonable that CCS limit its liability on individual cases. Many of the conditions known to CCS are complicated and extremely costly. Without a limitation as to liability to this Program, treatment funds might reach only a small segment of the population eligible under these Rules. Therefore, it is necessary and reasonable to establish a limitation on individual case liability so as to assure treatment services reimbursement for a larger number of eligible children. Past experience has shown that the established figure of $7,500 is reasonable and covers the major portion of the eligible cases known to CCS.

7 MCAR § 1.655 C. 5. This section is necessary and reasonable to specify the criteria upon which exceptions to the policy about routine care are made. There are instances when eligible children with special conditions cannot be provided routine care without specialized back-up services. Some conditions may make routine care not routine, e.g., hemophilia. For a child with hemophilia, the extraction of teeth may become a life threatening situation.

7 MCAR § 1.655 C. 6. This section is necessary to specify the limitations on authorization for individuals with hemophilia. These limitations are in keeping with the provisions of Minnesota Laws 1977, Chapter 453, Section 24.

7 MCAR § 1.655 D. E. These sections of the Rules are necessary to specify which treatment services are reimbursable and which are not reimbursable for individuals 21 years and over with hemophilia. The inclusions and prohibitions are necessary to implement the provisions of Minnesota Laws 1977, Chapter 453, Section 24.

7 MCAR § 1.656 ADMINISTRATION REIVEW PROCEDURES

This section of the Rules is necessary and reasonable to establish administrative procedures by which an applicant has recourse if dissatisified with a decision related to his/her eligibility status or cost-sharing determination. It provides a procedure for review and reconsideration of the administrative action taken, which is reasonable and readily available to applicants.

7 MCAR § 1.656 A. 1. It is reasonable and necessary that the Medical Director be provided written material stating why the request is being made, what is involved, and any previous actions that may have been taken. Written material is necessary so that documentation of the process exists. The Medical Director is ultimately accountable for the management of CCS: therefore, it is reasonable that the request be directed to that position. It is reasonable to specify a format so that the committee will have the information considered to be basic and essential to the review process.

7 MCAR § 1.656 A. 2. It is necessary and reasonable that CCS establish a time frame on which the review is to take place. This time frame insures that there will be a review within a reasonible period of time and that the applicant will have adequate notice. Past experience has demonstrated that this time period allows CCS and the applicant sufficient preparation time.

7 MCAR § 1.656 A. 3. It is necessary to have written documentation of all actions relevant to the review process. This section recognizes that applicants to the CCS Program come from all parts of the state. In some instances, it may be difficult for applicants to travel to Minneapolis for the review on the scheduled date. In the interest of fairness, the review will be rescheduled, when there is a valid reason an applicant cannot attend and wishes to do so.

7 MCAR § 1.656 A. 4. In the interest of fundamental fairness, it is necessary that the applicant and/or any person of his/her choosing be present at the review. It is the intent of this review that complete information be presented in order that it can be determined if previous decisions were made in keeping with the criteria and procedures governing the CCS Program as stated in these Rules.

7 MCAR § 1.656 A. 5. is necessary and reasonable so that both CCS and the applicant have documented evidence of actions taken and clear understanding of the reasons for the outcome of the review.

7 MCAR § 1.656 B. This section is necessary to inform applicants of the more formal appeal process available to those who want further review of the administrative decision. This section references the specific statutes governing this procedure.

7 MCAR § 1.657 RESPONSIBILITIES BETWEEN CCS AND SERVICE PROVIDERS

This proposed rule describes the responsibilities between CCS and the service providers used by the Program. It is reasonable and necessary to describe the specific responsibilities so that a clear understanding of the expectations and obligations of each party exists.

7 MCAR § 1.657 A. 1. So as to provide a coordinated approach and avoid duplication of effort, it is reasonable and necessary that pertinent diagnostic or treatment information related to an eligible child be shared with the service provider. In the interests of the privacy of information, such information shall not be transmitted without the informed written consent of the applicant.

7 MCAR § 1.657 A. 2. It is necessary and reasonable to establish a schedule for rates of reimbursement. CCS has chosen to use the same fees for medical, dental, and hospital care as are established by the Social Security Act, as amended Title XIX (Medical Assistance), Minnesota Department of Public Welfare. The Title XIX rates are established at the seventy-fifth percentile of usual and customary fees, as determined by the Department of Public Welfare. The Department of Public Welfare has the mechanism and capability for determining these rates. CCS does not have such capacity. The Department of Public Welfare (Medical Assistance section) furnishes CCS with this information each year, or as frequently as they are revised. Title XIX rates have been found to be at a level sufficient to maintain standards of quality relating to personnel and facilities.

7 MCAR § 1.657 A. 2. a. Some of the specialized services needed to assure maximum rehabilitation of children in the CCS Program may not be allowed by the Title XIX Program and thus, there will be no previously established rates for the service. It is necessary to state the criteria and factors that will be considered by the CCS Program in determining appropriate levels of reimbursement for the particular service. These criteria set forth a reasonable method of establishing and substantiating rates of payment that are sufficient to maintain the standards relating to personnel and care as contained in the federal regulations (42 CFR Part A § 51a.)

7 MCAR § 1.657 A. 2. b. This section is necessary because the federal regulations (42 CFR Part A § 51.a) governing the CCS Program require that the Title V, 42 USC, Chapter 7 monies available for services to children be the last dollar spent. This is reasonable since funds for this Program are limited. It is reasonable to apply other funds, e.g., insurance, Medical Assistance, when available to pay for the costs of care. This allows CCS to extend the funds available for treatment services. CCS does not require applicants to provide the actual payment from other sources before CCS reimbursement is made, only that arrangements for such payment have been made; CCS is then billed for the remaining expenses up to the maximum amount for which CCS is liable as defined in 7 MCAR § 1.655 (C)(4). This method allows CCS to have an accurate accounting of monies encumbered and the limitations of the Program funds.

7 MCAR § 1.657 A. 3. It is necessary and reasonable to review all reimbursement requests, which include medical reports, in order to assure fiscal and program accountability. The volume of requests that CCS handles is large. Based on past experience, 45 days is a reasonable amount of time in which ti complete an accurate review of reimbursement requests. It is necessary to specify what such a review involves so that service providers are aware of the procedures involved when they submit requests for reimbursement.

7 MCAR § 1.657 A. 4. is necessary and reasonable that services provided to eligible children be of high quality. The federal regulations (42 CFR, Part A §§ 51a.108, 110) governing the CCS Program require CCS to work toward the development, strengthening, and improvement of standards and services for children with handicaps. The criteria that service providers must meet in order to be eligible for participation in the CCS Program have been developed based on the following guidelines contained in the federal regulations:

a. "Best adapted for the attainment of the specific purpose."

b. "Assures a reasonably high standard of care."

c. "Meets state and local licensing laws."

d. "Is in substantial accordance with national standards."

To assure that children who participate in the CCS Program receive high quality services, it is necessary that service providers meet the criteria contained in these Rules.

It is necessary that service providers are aware of the criteria and procedures involved with regard to participation in the CCS Program.

7 MCAR § 1.657 A. 4. a. This section is necessary as it sets forth the minimum standards that facilities must meet in order to be utilized by service providers within the CCS Program. The standards which must be met by facilities to obtain JCAH accredidation and MDH licensure assure an acceptable level of quality care and it is, therefore, reasonable that CCS ask providers to meet these requirements.

7 MCAR § 1.657 A. 4. b. The criteria contained in this section of the Rules are necessary and reasonable and will assure standards relating to the quality of care required for the eligible children served by the CCS Program. The criteria contained in this section of the Rules provide some objective manifestation that the providers are qualified and have the necessary experience required to treat the handicapping condition of children known to CCS.

Many of the children served by the CCS Program have multiple and complicated medical and surgical problems. These problems are most responsive to a comprehensive, coordinated approach. It is reasonable that physicians and dentists serving these children function in the team approach. This coordination can also prevent the fragmentation of care, which is not in the best interest of the eligible children.

7 MCAR § 1.657 A. 4. c.d. is necessary to establish the criteria utilized in the selection of non-medical or dental service providers, e.g., occupational and physical therapists, audiologists, speech therapists, etc. Individuals who have already met the criteria of their professions to be considered qualified are acceptable to CCS and provide some evidence that they will assure a minimum standard of care. These criteria are also consistent with national standards relating to quality of care for these providers. It is reasonable to require that these groups of providers meet the criteria contained in the Rules.

7 MCAR § 1.657 A. 5. In the interests of fundamental fairness, it is necessary and reasonable that CCS should provide an administrative procedure for those providers who are not approved and who wish reconsideration. It is reasonable that the Medical Director receive the request since that position is responsible for the management of the CCS Program. It is further necessary to reference the specific statutes under which a more formal hearing shall be conducted.

7 MCAR § 1.657 A. 6. is necessary and reasonable to describe the type of information maintained in an individual's case record. Maintenance of such information is necessary for the effective planning and documentation of services related to that individual for medical/legal and financial reasons. The federal regulations (42 CFR Part A, § 51a.112) require that such information be protected from access without consent of applicant. This section references the appropriate state statutes which safeguard the individual's rights with regard to data privacy. CCS records are temporarily classified as private. This means that an individual may see all information contained in the record, but no information is released without the written consent of that individual.

7 MCAR § 1.657 B. 1. It is necessary to require this section in that federal regulations (42 CFR Part A § 51a.111) require that all services with the exception of emergencies as defined in these Rules be prior authorized. State funds are used to match federal dollars and are, therefore, subject to the same requirement. It is, therefore, necessary that a provider understand and be aware of this expectation. The authorization form specifies the service(s) to be provided and the conditions of payment. CCS will not be responsible for payment of services which they have not authorized. The prior authorization of services by CCS allows the Program to assess the timeliness and appropriateness of the services provided and assures fiscal accountability.

7 MCAR § 1.657 B. 2. It is necessary and reasonable that information related to an individual's condition be supplied to CCS in order to facilitate coordination and continuity in planning for that individual and his/her care. Many of the individuals known to CCS have multiple handicaps and may require and receive services from a variety of providers. The individual provider may not have a total profile of that individual. CCS maintains such a profile as they have responsibility for the case management of the care for the particular child.

Cost related information is necessary to determine that the conditions of payment have been fulfilled and to assure fiscal accountability.

7 MCAR § 1.657 B. 3. This section is necessary to specify that Title V, USC 42, Chapter 7 regulations governing the CCS Program require that the monies available under this Program be the last dollar spent; therefore, CCS does not reimburse providers where other monies are available to cover the costs of services. By requesting that providers arrange for the other payments before billing CCS for the remaining costs, CCS is able to maximize the use of its limited funds. The CCS Program recognizes that third-party payments to providers can sometimes be unreasonably delayed. In the interests of fairness to providers, CCS has established a procedure whereby providers can submit those bills where payment

from third-parties is delayed for extended periods, and then reimburse CCS when they receive payment. It is reasonable and necessary that CCS establish criteria as to what constitutes an unreasonable delay. Past experience has shown that payment processing by other third-party payers is usually accomplished within a 90-day period. It is, therefore, reasonable that anything over 90 days be deemed to constitute an unreasonable delay. CCS does not have the capability of routinely reimbursing providers before other third-party payments are received. It can only be done as an exception to normal procedures.

7 MCAR § 1.657 B. 4. It is reasonable and necessary to specify this section in that federal regulations (42 CFR Part A § 51a.115) stipulate that providers may not charge or bill an individual or his family for the cost of treatment beyond the cost-sharing amount determined by the CCS Program and detailed on the authorization form. This amount is based on what has previously been determined to be the applicant's ability to pay. Some applicants will not have to share in the cost of treatment because upon application of the cost-sharing calculations, their income has been found to be below the level at which they could realisitically be expected to have any discretionary income. Where an applicant has a cost-sharing requirement, it is reasonable that they not be required to pay more than the original amount determined. This understanding is included in the cost-sharing agreement signed by applicants as described in 7 MCAR § 1.654 (B). In addition, this limitation is stated on the authorization form, which is to be signed by the provider. Providers whose services are utilized by CCS have previously agreed to conform to established CCS rules and procedures.

ADMIN 1000 (Rev. 1-78)
BI 00006-01

STATE OF MINNESOTA

DEPARTMENT: Health/Services for Children with Handicaps

Office Memorandum

TO : Terry P. O'Brien
Special Assistant
Attorney General

DATE: April 13, 1979

FROM : Richard P. Nelson, M.D. RN
Director
Services for Children with Handicaps

PHONE:

SUBJECT: Additional Justification Statement for the use of Medical Assistance Rate Schedule in the SCH Treatment Reimbursement

Section 7 MCAR 1.657 entitled "Responsibilities Between CCS and Services Providers" states in paragraph A-2 that SCH (CCS) shall pay service providers at the same rates for medical, dental and hospital care as are established by the Minnesota Department of Public Welfare pursuant to Title XIX. In our original justification statement we emphasized that the rate schedule established by the Minnesota Department of Public Welfare identifies fees at the seventy-fifth percentile of usual and customary fees. It was also observed that this complex schedule is an undertaking beyond the capacity of the Services for Children with Handicaps program.

It is reasonable that this program utilize a complex schedule established by another agency of state government which has the need to promulgate such a schedule based upon the volume of patient care transactions reimbursed through Medical Assistance. By agreeing to participate in the SCH program physicians and other health care providers acknowledge the appropriateness of this rate schedule and view it as a consistent and impartial means for our program to provide reimbursement for authorized care.

The Medical Assistance rate schedule is the only such schedule available to the Program covering thousands of procedures and categories of care. It would be essentially impossible for the Program to independently generate the schedule.

The Medical Assistance rate schedule is not used in an automated fashion but through careful review of invoices from health care providers identifying specific procedures and elements of care.

RPN:ck

bcc: Alpha Adkins
Nancy Okinow

PRINTED ON RECYCLED PAPER

DRAFT

DEPARTMENT OF HEALTH

Proposed Rules Relating To Crippled Children Services Criteria, Procedures And Responsibilities for Eligibility, Cost-Sharing and Reimbursement

Amendments to Rules as Proposed

Chapter Thirty-one: 7 MCAR §§ 1.651 - 1.657

Prior to public hearings scheduled to consider the proposed Minnesota Department of Health rules relating to Crippled Children Services criteria, procedures and responsibilities for eligibility, cost-sharing and reimbursement, Crippled Children Services (CCS) has decided to change the title of the program. At the hearings, Crippled Children Services will be proposing an amendment to the rules, as presented, which would allow CCS to accomplish this.

AMENDMENT ONE

The proposed amendment reads as follows:

It is proposed that the title of the Crippled Children Services (CCS) program in Minnesota shall be changed to Services for Children with Handicaps (SCH). All references to Crippled Children Services throughout the text of the proposed rules shall be changed to correspond to the new title.

STATEMENT OF NEED AND REASONABLENESS

The title of the Crippled Children Services (CCS) program has a long history dating from the program's creation as a result of the Social Security Acto of 1935. Initially, CCS concerned itself primarily with children who had orthopedic problems. As CCS evolved over the years, other handicapping conditions were included. Today, the program offers services to children who have a broad range of handicapping conditions that i[illegible]ore with their normal growth and

development. Consequently, the title of the program no longer accurately describes the population of served children.

The title of the Crippled Children Services program could conceivably lead some individuals to believe that the services of the program would not be appropriate to their needs. In addition, the old program title has a stigmatizing effect and may discourage new families from initiating contact with the program.

The new title, Services for Children with Handicaps, is a reasonable replacement. The program provides services for those children who have a handicapping condition or a suspected handicapping condition, and does not provide general health care to well children. This title appropriately allows the public to be aware of the general purpose of the program and for whom its services are intended.

AMENDMENT TWO

It is proposed that 7 MCAR § 1.655 C.4 be amended to read as follows: Within any 12 month period, CCS shall pay no more than $10,000 for the care of an individual.

STATEMENT OF NEED AND REASONABLENESS

In order to adequately serve a significant number of children whose costs of care currently fall between the present ceiling of $6600 and the higher amount, the ceiling should be raised to $10,000. CCS does have limited funds available for treatment services based upon the federal formula contained in 42 CFR, Part A § 51a.123 and legislative appropriation. In an effort to provide some financial aid with the costs of treatment to a larger group of individuals, it is necessary and reasonable that CCS limit its liability on individual

cases. However, because of more accurate data on the number of individual cases whose costs of care actually go over the present established limit, CCS feels that the ceiling on liability for care can reasonably be raised to $10,000. This increase would enhance the program's ability to adequately serve a significant number of children whose costs of care fall over the current ceiling liability and not diminish the program's capacity for providing some financial assistance to a large number of individuals.

minnesota department of health
717 s.e. delaware st. minneapolis 55440
(612) 296-5221

May 18, 1979

Mr. Peter Erickson
Office of Hearing Examiners
1745 University Avenue
Room 300
St. Paul, Minnesota 55104

Dear Mr. Erickson:

The Services for Children with Handicaps (formerly CCS) Program of the Minnesota Department of Health wishes to respond to comments offered by the public at the recent Rules hearing for the Program and to correspondence received by your office regarding these Rules Chapter Thirty One: 7 MCAR §§ 1.651 to 1.657, as well as to offer further justification and clarification based upon these public comments.

This response will review the Rules by numerical section, which should facilitate an orderly and comprehensive reply to the issues in question. Where applicable, the reader will be referred to the justification prepared by the Department prior to the public hearing or introduced at the hearing. Many issues were cited by several members of the public and will be answered collectively.

7 MCAR § 1.651 General

This section summarizes the scope of the Services for Children with Handicaps program covered by these Rules and further delineates useful definitions of thirty terms employed by SCH in the determination of eligibility, cost-sharing and reimbursement. A question was raised by Mrs. Bernadette Hughes at the Hearing regarding the utilization of the state appropriation by the Department. This appropriation, a significant portion of which is designated by Statute for care of handicapped children at the Gillette Children's Hospital, does not restrict SCH to utilize a broad variety of qualified health care providers. Furthermore, the concept of family cost-sharing employed by SCH is identical in philosophy to that utilized by the Gillette Hospital in their determination of the family's responsibility for care at that facility.

The comment by Ms. Fithian questioning the statutory authority for the Rules is addressed in the justification statement (page 1).

It was suggested in testimony by Mrs. Hughes, and in correspondence from Ms. Fithian that the cost-sharing as defined in these Rules be substituted with a co-payment for each procedure authorized as in some insurance plans. This was considered, as an option, when these Rules were being drafted. It is the consensus of the staff responsible, that such a co-payment plan would be inequitable and pose the added financial hardship on those children SCH considers to be the priority group to be served. Children with the most complex multiple problems frequently require a variety of different services, possibly on a frequent basis. A co-payment for each episode of care could be far more costly than the cost-sharing plan defined by these Rules. This cost-sharing schedule, based on the concept of the ability to pay, assures the family a maximum liability for costs of care during the period of eligibility - at least for the costs incurred for the eligible handicapping condition(s). This is a potentially more beneficial arrangement than a per episode co-payment.

Ms. Fithian refers to restructuring the program to provide services close to home. This concept is beyond the scope of these Rules; but in terms of the Rules, there are no restrictions to preclude care in various locations in the state, if providers of care meet the qualifications as specified in 7 MCAR § 1.657.

Dr. Flom expresses concern for the lack of definition for "eligible individuals with handicaps". The statement of justification speaks to this point; and it is our understanding that the purpose of these Rules as stated in 7 MCAR § 1.651 is to define "eligibility" under this program.

Several clarifications have been requested at the Hearing and in letters from Mary Lou Fithian (April 25, 1979) and Toni Lippert (May 9, 1979) in the definitions sub-section:

Definition 3 "allowable deductions".

The Department concurs with the observations of Mrs. Hughes and others that allowance should be made for health related expenses incurred by families. Therefore, we propose that the clarifying phrase and other health care-related expenses be inserted so that paragraph a reads, Medical-dental expenses for treatment and other health care-related expenses paid during the previous twelve months which were not reimbursed by a third-party payer such as insurance or Title XIX (Medical Assistance). This clarification does not constitute substantive change, but further defines the meaning to assure understanding by the public. We also agree with Mrs. Hughes that the deduction for automobile travel expenses should be raised to $.17 per mile which would be more consistent with current state agency mileage reimbursement practices and recognizes accelerated

inflation in energy costs. Therefore, we recommend $.17 be inserted in b 1) instead of $.10. Ten cents per mile had been a fair reimbursement until recent months, but it is reasonable to modify it now.

Definition 13 "Diagnostic evaluation".

In reference to the letter of Ms. Lippert regarding the composition of the team of professionals, the definition as stated does not exclude any non-health professional from participation.

Definition 17 "Household member deduction".

This definition permits the deduction of $1,000 per household member from the total of includable assets used in the calculation of the adjusted SCH gross income. This monetary figure is consistent with meaningful deductions permitted by tax authorities and other public agencies in similar calculations.

Definition 18 "Includable assets".

This does not refer to capital assets as is further delineated in the justification statement (page 4).

Definition 19 "Long-term physically handicapping condition".

This definition was subject to comment from the Regional HEW office. We concur in principle with the comments offered by Doctors Dyer and Stemmle. SCH, as stated in the justification statement (page 4), recognizes the extensive needs of many children with chronic illness and handicapping conditions but finds it reasonable and necessary to define medical eligibility on the basis of a definition that realistically reflects its resources. The definition of a crippled child listed in Title V, Section 514 of the Social Security Act as an "individual under the age of 21 who has an organic disease, defect, or condition which may hinder the achievement of normal growth and development" is remarkably broad in context. Conventional wisdom would imply that most diseases affecting children, excepting those of the most trivial, transitory nature, have the potential, without appropriate medical intervention, to result in impaired growth and development. Historically, it has been beyond the capability of any Title V Crippled Children's Program in any state or territory to provide the full range of reimbursement for pediatric care necessary to alleviate potential crippling conditions from a host of disease entities. The definition, therefore, in this section is a reasonable attempt to indicate the priorities of SCH in alleviating the most severe needs of children. It is reasonable and necessary to define for administrative equity which children of all children are eligible for treatment resources of this program. In recognition of the concerns expressed with the definition, SCH wishes to clarify the definition by substituting the following sentence under definition 19: Handicapping condition means a physical condition which requires extended, sequential medical, surgical and/or rehabilitative intervention as determined by a diagnostic evaluation and approved by SCH. This re-statement of the definition does not

substantively change the definition but accommodates to the misunderstanding implied in Dr. Dyer's leeter, by precluding the possibility that some children will not be served as a result of the literal use of "two years" in the definition.

Definition 22, "Prior authorization".

Dr. Flom questions the appropriateness of the SCH agent making prior authorization decision. The medical director of SCH by federal regulation is a board eligible and board certified podiatrician; as such all delegation and responsibility for these decisions is under the authority of the medical director. Prior authorization is not synonymous with making decisions as to diagnosis and treatment as is implied by Dr. Flom's statement.

The suggestion of Ms. Lippert to insert "written" in the definition of prior authorization, upon due consideration we feel, does further clarify the definition.

Definition 24 "Self-supporting individual".

This definition is consistent with that of the Internal Revenue Service.

Other questions regarding definitions raised by the public and in Ms. Fithian's letter are clarified in the justification statement on pages 5 and 6.

7 MCAR § 1.652 Applicant Eligibility for Diagnostic Evaluation

Mr. James R. Martin presented testimony at the Hearing questioning the restriction that limits services to those individuals under 21 who have phenylketonuria. The justification statement clearly explains the program's inability under federal regulations to serve individuals 21 years of age or over using federal formula funds. The only current exceptions (Cystic Fibrosis, Hemophilia, and Somatotropin) to this policy have been made possible through specific Minnesota State Statutes.

Dr. Flom asks who makes the determination that a child is suspected of having a handicap. There are no exclusions to who makes this determination. The intent of SCH is to find any and all children "suspected" of having a handicap. Traditionally children come to the program for diagnostic evaluation through family, family physicians, nurses, teachers or other interested persons who are familiar with a child.

7 MCAR § 1.653 Applicant Eligibility for Treatment Services

Ms. Fithian's letter refers to residency in Minnesota as a condition of eligibility. The justification statement (page 7) discusses the concept of residency as utilized in this program. It is the simple use of the word indicating an applicant must indicate he/she lives in the State of Minnesota in order to be eligible for the program. No length of time of residence or specific documentation of residence is required.

To be consistent with the previous recommended change in definition pertaining to "handicapping condition", we amend A 3 of this part to read: A child who

has a diagnosed handicapping condition as defined in these Rules.

7 MCAR § 1.654 Application and Cost-sharing for Applicants

Dr. Flom questions use of "this time" in A 6-c. There appears to be a misunderstanding in his reading of this section. As in all new applications to SCH, the eligibility period is for one year from the date eligibility is established. This section provides for administratively accepting applications for children with unanticipated treatment services.

Part B, "Cost-sharing" received comment from Dr. Roger Edson, Mary Lee Fithian, Philip Norman, Bernadette Hughes, and Dr. Robert Flom in their letters and in testimony by health care providers at the Hearing. The justification statement (pages 11 and 12) provides the reasonable and rational basis for the cost-sharing principle. Basically, cost-sharing establishes a mechanism for families with greater financial resources to utilize a proportionate shareof these resources in order to obtain health care services for their handicapped child as compared to a family with more limited financial resources. It is reasonable and necessary to apply a sliding scale in accordance with ability to pay. SCH recognizes the concern that some individuals and agencies have that the dollar amount determined as a family's or individual's cost-share may be significant for many middle income families. The specific cost-share schedule delineated in these Rules is a reasonable attempt to equitably make available fiscal resources to offset costs of care for Minnesota's population of handicapped children. The Rules propose a schedule for cost-sharing consistent with known available fiscal information. Further liberalization of the cost-sharing schedule could jeopardize the SCH financial ability to reimburse for care as outlined in these Rules during a full budgetary period and thus distribute these public resources on an inequitable basis. Over the next few years as experience accrues, average income and funding levels change, modifications in the cost-sharing schedule can be anticipated, requiring a re-opening of the rule-making process in keeping with the Administrative Procedures Act.

In reference to the comments made by Mrs. Hughes and others regarding apportioning cost-sharing, it is possible within these Rules to apportion a family's cost-share amount among a number of health care episodes during a twelve month eligibility period if such episodes are designated in the treatment plan. For some individuals and families, this will avoid the one-time large cost-share prior to the initiation of a single treatment event. In response to Mrs. Hughes' concern that advance payment of cost-sharing is required, these Rules do not require a family to pay the cost-share amount prior to any authorization for care by SCH. They are asked to arrange for payment and may sign an agreement with the health care provider(s) that the specified amount of the cost-share will be paid through some specified plan. Terms of payment may be arranged between the family or individual and the health care provider and such terms do not delay the SCH payment fo- that health care episode.

The cost-share schedule in the Rules was based on mean income levels for families of 1 through 10 members (justification statement pages 18 and 19). Family income does not increase in any specific proportion as family size increases. This explains the apparent contradiction, referred to by Mrs. Hughes, that larger families (greater than 6 members) have a smaller increment in the cost-share baseline for each additional family member.

At the hearing, we agreed to clarify Sentence 5a to include the word annual. The sentence will read: An increase or decrease of 5% in the annual adjusted gross income from that indicated on the application. This is not a substantive change but provides clarity to the statement.

With regard to Ms. Fithian's comments, the justification statement (page 13) adequately refers to the rationale for the allowed adjustments in cost-sharing in paragraph 5. The administration of the program will be responsible for reviewing individual applications and maintaining a consistent policy in making such adjustments. Ms. Lippert's letter suggested adding another criteria for adjusting cost-sharing. We suggest that this concept is taken into account in "allowable deductions" (7 MCAR § 1.651 B.3) on a routine basis and does not require consideration as an exception. The question in letters (testimony) of Mr. Aitchison and Mr. Norman indicates a misunderstanding of the cost-share amount referred to in paragraph 7 when more than one eligible individual lives in a single household. The Rule and justification statement both clearly indicate that in no situation will a family or individual be responsible for more than one cost-share amount, regardless of the number of eligible children in the family.

7 MCAR § 1.655 Reimbursement for Services

The letter of Ms. Fithian suggests that consideration be given to decentralization of services. SCH is committed to an expansion of participation by qualified health care providers throughout Minnesota and neighboring states. Utilization of the program will ultimately be best enhanced through the efforts of the program's staff and through its direct clinical activities.

Ms. Fithian's concerns about physician orientation are beyond the scope of these Rules; but orientation of the consumer and provider community is an on-going regular staff responsibility within SCH. Ms. Fithian asks if emergency treatment must occur in an approved facility. Yes, it does; in the best interest of the child. However, it is important to point out - there are no unlicensed hospitals in Minnesota.

Participating health care providers are aware of this required notification and have shared responsibility to inform SCH when an authorization is required. The Rule does not preclude parental involvement, but in fact the authorization agreement is between SCH and the provider.

In response to concerns identified in letters from Ms. Lippert, Mrs. Hughes, and Ms. Fithian related to need to clarify reimbursement for equipment, we offer the following changes in wording in this section to clarify intent and to be more understandable to the reader. After C 3, add the phrase, unless no other resource is available, so that the sentence reads: SCH shall not authorize reimbursement for costs of equipment such as hospital beds or wheel chairs unless no other resource is available. It has been SCH's experience that in most situations these resources are available through a variety of voluntary or service-oriented groups. It is in the best interest of the public to give priority to SCH expenditures for reimbursement for which there are no other resources. It is necessary and reasonable to set such priorities for the use of limited funds.

Prior to the Rule Hearing, the Program requested a change in the maximum reimbursable figure in C4 to $10,000. This has been supported in both verbal and written testimony.

Correspondence from Dr. Edson and Mr. Rosoff clearly articulate the treatment needs of the population of children and adults with hemophilia. Specific questions have been raised regarding the present inability of SCH to pay for extensive dental care for adults age 21 years and over. The provisions of the legislation prescribed that SCH provide services to adults to assist in the costs of infusion therapy necessary to control bleeding in this disorder. Furthermore, periodic evaluation and some rehabilitative needs were addressed. The statute did not provide for in-hospital or other specialist treatment care, and it is SCH's conclusion that further legislation would be required in order to consider such care within the scope of these Rules.

To clarify a concern expressed by Mr. Norman, in E4, the phrase unless it is a medical emergency as determined by the medical director should be added following the word transportation. The new sentence will then read, Transportation, unless it is a medical emergency as determined by the medical director.

7 MCAR § 1.656 Administrative Review Procedures

Ms. Lippert and Ms. Fithian expressed concerns relative to the informal administrative review procedures. The justification statement (pages 15-16) responds to most of their concerns. Information about this process is routinely communicated as part of written information to all applicants. This Rule enables an applicant or the professional representing an agency involved in the provision of service to the applicant to initiate an administrative review of any eligibility decision made by SCH. To further clarify this intent, we propose that the phrase of any agency be inserted in paragraph A so that this sentence shall read: An applicant and/or staff person of any agency may request, at any time, a review..." The Rule

does not restrict SCH to schedule administrative reviews at a place and time convenient to the family and other agencies involved with the applicant. It would be in the best interests of all parties to schedule the review at the convenience of the applicant. In response to Ms. Fithian's statement, the Minnesota Administrative Procedures Act stipulates that the Chief officer of the agency (Commissioner of Health) would become involved in the formal hearing process.

7 MCAR § 1.657 Responsibilities Between SCH and Service Providers

Dr. Flom questions the use of referral information. The Rule states "with the written consent of the applicant" which recognizes the sensitivity of medical information in the Data Privacy Act.

Dr. Flom recommends that SCH reimbursement of treatment cost be made only after other third party payer and cost-share amounts have been collected by the provider. SCH feels this would unnecessarily delay SCH payment to providers and would be a disservice to them.

We concur with the observations of Mr. Aitchison and Mr. Norman that paragraph 4, sentence a does not recognize an appropriate accreditation recognition for rehabilitation centers. Therefore, we propose inserting "or their appropriate accreditation body" to clarify this statement. 3a shall then read: Hospitals and specialized medical centers shall be approved by the Joint Commission on the Accreditation of Hospitals (JCAH), or the appropriate accrediation body, and licensed by the Minnesota Department of Health or their respective state. This addition accommodates to an inadvertant oversight and assures clarity of this statement; it is not considered a substantive change.

In response to Dr. Robert Fitzgerald, this Rule does not restrict the participation by any health care provider in Minnesota on the basis of specific licensure. By virtue of the special population of children served, SCH attempts to identify physicians, dentists, and other health professionals who by virtue of their training and experience demonstrated by licensure, appropriate board eligibility, registration or certification, have recognized ability and interest in serving the needs of these children with handicaps. Specialization of service and multi-disciplinary work setting are the two primary determinants in professional participation in SCH. This policy is consistent with Federal Guidelines for Crippled Children Services Programs.

We would clarify a comment in Ms. Fithian's letter that "SCH clients are used to train specialists" (page 4). Children cared for in academic (teaching) hospital settings certainly have exposure to physician's at various stages in training. However, primary responsibility for management

of children authorized for care in these settings rests with the board qualified specialists as defined in these Rules.

In reference to the concern of Mrs. Hughes that there are delays in the processing of authorizations, it is the continuing objective of SCH to provide efficient handling of all applications, requests for authorization for service, re-applications and payment of bills for authorized health care. SCH has the capability of attempting to deal individually with health care providers to assure understanding of SCH Rules and Procedures, as well as the ability of the provider to respond to these Rules and Procedures.

Dr. Flom comments that "case report" is not defined. The justification statement (page 19) describes the necessity for a case report. In addition, in keeping with these Rules, the applicant has given consent to SCH to share case related information with doctors, hospitals, and other specified parties. The written authorization form and instructions indicate the nature of the cost information and case report information requested of the provider. These reports are specific to the treatment or service authorized.

Summary Statement

The Program has welcomed the wide range of response to these Rules. We do not consider these proposed Rules, as clarified, to be a fixed set of administrative procedures for the indefinite future. We anticipate necessary revisions as resources change, when we have added knowledge to make further refinements. It is important to recognize that Services For Children With Handicaps of the Minnesota Department of Health is not the exclusive health service agency or resource for handicapped children in Minnesota. Rather, it is one of a complex series of public and private resources in Minnesota charged to care for needs of children with special problems.

Ultimately, SCH will be most innovative with maximum input from all individuals and agencies concerned for the welfare of individuals with handicapping conditions in Minnesota.

Sincerely,

Richard P. Nelson, M.D.
Director
Services for Children
with Handicaps

RPN:ck

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF HEALTH

In the Matter of Proposed Rules Relating to Crippled Childrens Services Criteria, Procedures and Responsibilities for Eligibility, Cost-Sharing and Reimbursement.

REPORT OF THE HEARING EXAMINER

The above-entitled matter came on for hearing before Hearing Examiner Peter C. Erickson of the State Office of Hearing Examiners at 9:00 a.m. on Wednesday, April 25, 1979 in the St. Cloud City Hall, St. Cloud, Minnesota, and at 9:30 a.m. on Friday, April 27, 1979, in Room 105 of the Minnesota Department of Health Building, Minneapolis, Minnesota.

Terry P. O'Brien, Special Assistant Attorney General, appeared as counsel on behalf of the Department of Health. Dr. Richard P. Nelson, Director of Crippled Children's Services, testified in support of the proposed rules on behalf of the Department. The hearing continued until all interested groups or persons had had an opportunity to be heard concerning the adoption of the proposed rules.

Pursuant to Minn. Stat. sec. 15.0412, subd. 4, this Report shall be available for review to all affected individuals upon request for at least five days. Thereafter, the Minnesota Department of Health shall, if it proposes to adopt the rules as originally proposed or amended, submit a copy of the Order Adopting Rules, a copy of any additional agency findings, a copy of the rules as originally proposed, and a copy of the rules as adopted to the Chief Hearing Examiner for review pursuant to Minn. Stat. sec. 15.052, subd. 4. The submission to the Chief Hearing Examiner shall precede review by the Attorney General. The Chief Hearing Examiner shall complete his review and submit his report to the Deparment on the issues of substantial changes in the rule and compliance with Minn. Stat. sec. 15.0412 within ten calendar days. The Department of Health will be responsible for filing the rules with the Attorney General and for notifying persons who have indicated that they wish to be notified ot such filing.

Based upon all the records and proceedings herein, the Examiner makes the following:

FINDINGS OF FACT

1. On March 5, 1979, the Department filed the following documents with the Chief Hearing Examiner:

   (a) A copy of the proposed rules.
   (b) The Order for Hearing proposed to be issued.
   (c) The Notice of Hearing proposed to be issued.
   (d) A Statement of the number of persons expected to attend the hearing and estimated length of the Agency's presentation.

2. On March 19, 1979, a Notice of Hearing and a copy of the proposed rules were published at 3 State Register 1749.

3. On March 19, 1979, the Department mailed the Notice of Hearing to all persons and associations who had registered their names with the Secretary of State for the purpose of receiving such notice.

4. On March 30, 1979, the Department filed the following documents:

(a) The Order for Hearing and authorizing resolution.
(b) The Notice of Hearing as mailed.
(c) The Affidavit of Receipt of the Secretary of State's list.
(d) The Affidavit of Mailing the Notice to all persons on the Secretary of State's list.
(e) The Secretary of State's Certificate and list.
(f) The Statement of Need and Reasonableness.
(g) All materials received following a Notice of Intent to Solicit Outside Opinion published at 1 State Register 961 (December 27, 1976)
(h) The names of Department personnel who will represent the Agency at the hearing together with the names of any other witnesses solicited by the Agency to appear on its behalf.

The documents were available for inspection at the Office of Hearing Examiners from the date of filing to the date of the hearing.

5. The record remained open through May 18, 1979, for the receipt of written comments and statements, the period having been extended by order of the Hearing Examiner to 20 calendar days following the hearing.

6. The Department asserts that statutory authority for the promulgation of the proposed rules is contained in Minn. Stat. secs. 144.05, 144.06, 144.07, 144.09, 144.10, 144.11 and 144.12 (1978). Further, pursuant to Minn. Stat. sec. 16.125, Department of Administration Reorganization Order No. 101, dated March 2, 1979, has vested within the Department of Health authority to implement Minn. Stat. secs. 250.05, 256.01, subd. 2(3) and (5), 256.011, 257.175 and 260.35 (1978) insofar as these statutes concern crippled children's services. Statutory authority regarding services for persons with cystic fibrosis is found in Minn. Stat. sec. 144.146 (1978); and for persons with hemophilia in Minn. Laws 1977, Ch. 453, sec. 24.

7. The above-captioned rules are new rules of the Department of Health which address the criteria, procedures and responsibilities relating to services authorized by the Commissioner of Health to help diagnose and treat handicapping conditions in children and in adults with cystic fibrosis or hemophilia. The Department proposes to adopt these rules in order to bring the Department into compliance with existing state and federal legislation concerning the reimbursement of service costs to children and to provide notice of the criteria and procedures used for those persons and/or organizations seeking crippled children's services and/or reimbursement for those services.

8. Proposed 7 MCAR sec. 1.651 A. (hereinafter 7 MCAR will be omitted from the citations) provides an introductory explanation to the purposes of the rules. The Department has amended the title of the program addressed in the rules by deleting reference to "Crippled Childrens Services (CCS)" and substituting in its place the term "Services for Children with Handicaps (SCH)".

9. Proposed sec. 1.651 B. sets out definitions for thirty terms which are used in the rules. These definitions are necessary for a uniform interpretation of the rules.

a. Regarding the definition of "allowable deductions", Mrs. Bernadette Hughes commented that health-related expenses should be included as a deduction. Also, several persons commented that the deduction for car travel expenses should be raised from ten cents to a more realistic amount. The Department responded as follows:

> The Department concurs with the observations of Mrs. Hughes and others that allowance should be made for health related expenses incurred by families. Therefore, we propose that the clarifying phrase and other health care-related expenses be inserted so that paragraph a reads, Medical-dental expenses for treatment and other health care-related expenses paid during the previous twelve months which were not reimbursed by a third-party payer such as insurance or Title XIX (Medical Assistance). This clarification does not constitute substantive change, but further defines the meaning to assure understanding by the public. We also agree with Mrs. Hughes that the deduction for automobile travel expenses should be raised to $.17 per mile which would be more consistent with current state agency mileage reimbursement practices and recognizes accelerated inflation in energy costs. Therefore, we recommend $.17 be inserted in b 1) instead of $.10. Ten cents per mile had been a fair reimbursement until recent months, but it is reasonable to modify it now.

As amended, the Examiner finds the definition of "allowable expenses" to be both needed and reasonable.

b. The Region XI Developmental Disabilities Task Force suggested that the definition of "child with a handicap" include language regarding mentally handicapping conditions. The Minnesota Medical Association (MMA) contends that the definition is "unduly broad and ambiguous". The Examiner finds that the definition of "child with a handicap", as proposed, is both needed and reasonable. However, the concern regarding mental handicaps should be further examined in the context of the definition herein and also in the definition of "treatment plan".

c. Region XI commented that the definition of "diagnostic evaluation" views that process from a medical perspective only. The MMA also objects to the board-certification or eligibility requirement for specialists. The Association is concerned about a disruption in the delivery of health care in rural Minnesota or for a solo family physician. The Examiner finds that the definition of "diagnostic evaluation", as proposed, is both needed and reasonable.

d. The United States Department of Health, Education and Welfare (HEW) commented that the definition of "long-term physically handicapping condition" may have a result which is contrary to the authorizing federal legislation. HEW contends that the "two-year" provision in the definition will foreclose treatment services from children who would be eligible according to federal law. The Department responded to these comments by recommending that the definition be rewritten as follows:

> Handicapping condition means a physical condition which requires extended, sequential, medical, surgical and/or rehabilitative intervention as determined by a diagnostic evaluation and approved by SCH.

As amended, the Examienr finds that the definition is both needed and reasonable.

e. Region XI suggested that the definition of "prior authorization" be amended by adding the word written as follows: "Prior authorization means a written agreement . . ." The Department concurred in this proposal. The Examiner finds that, as amended, the proposed definition is both needed and reasonable.

f. All of the definitions, sec. 1.651 B.1.30., as recommended to be amended above in paragraphs a., d. and e., are found to be both needed and reasonable.

10. Proposed sec. 1.652, Applicant Eligiblity for Diagnostic Evaluation, establishes the eligibility criteria for a diagnostic evaluation by SCH. An applicant is required to complete an application form which asks for basic qualifying information. Applicants are required to make use of available third-party reimbursement sources; however, there are no out-of-pocket costs to the applicant.

a. Dr. James R. Martin presented testimony at the hearing questioning the restriction that limits services to those individuals under 21 who have phenylketonuria. The Department stated that federal regulations require this restriction for the use of federal funds. The only exceptions have been made possible through specific Minnesota Statutes.

b. The Examiner finds that proposed sec. 1.652 is both needed and reasonable.

11. Proposed sec. 1.653, Applicant Eligibility for Treatment Services, sets forth the criteria and requirements governing an applicant's eligibility for reimbursement for the costs of treatment services. In order to be consistent with the amendment made to the definition of "handicapping condition", the Department proposed to amend sec. 1.653 A.3. to read: A child who has a diagnosed handicapping condition as defined in these Rules. The Examiner finds that, as amended, proposed sec. 1.653 is both needed and reasonable.

12. Proposed sec. 1.654, Application and Cost-sharing for Applicants, sets forth the procedures whereby an applicant may apply for services, and a determination of cost-sharing is made.

a. Letters from Kenneth Aitchison and Phillip Norman of the Medical Center Rehabilitation Hospital commented that the cost-sharing method would place an undue hardship on families which have more than one handicapped child. The Department stated, however, that the rule provides that a family shall be responsible for only one cost-share amount, regardless of the number of eligible children in the family.

b. At hearing, the Department amended sec. 1.654 B.5.a. to read: . . . decrease of 5% in the annual adjusted gross income. . ." for the purpose of clarity.

c. Several persons commented upon the appropriateness of the cost-sharing method set out in the rules. The Department responded to these comments as follows:

> Basically, cost-sharing establishes a mechanism for families with greater financial resources to utilize a proportionate share of these resources in order to obtain health care services for their handicapped child as compared to a family with more limited financial resources. It is reasonable and necessary to apply a sliding scale in accordance with ability to pay. SCH recognizes the concern that some individuals and agencies have that the dollar amount determined as

a famiy's or individual's cost-share may be significant for many middle income families. The specific cost-share schedule delineated in these Rules is a reasonable attempt to equitably make available fiscal resources to offset costs of care for Minnesota's population of handicapped children. The Rules propose a schedule for cost-sharing consistent with known available fiscal information. Further liberalization of the cost-sharing schedule could jeopardize the SCH financial ability to reimburse for care as outlined in these Rules during a full budgetary period and thus distribute these public resources on an inequitable basis. Over the next few years as experience accrues, average income and funding levels change, modifications in the cost-sharing schedule can be anticipated, requiring a re-opening of the rule-making process in keeping with the Administrative Procedures Act.

d. The Examiner finds that proposed sec. 1.654, as amended in paragraph b. above, is both needed and reasonable.

13. Proposed sec. 1.655, Reimbursement for Services, specifies the conditions necessary for reimbursements to be authorized by SCH and the limitations on such authorizations.

a. Several persons commented that the prohibition of reimbursement for the costs of medical equipment was unreasonable. The Department has proposed to amend the section to read: "SCH shall not authorize reimbursement for costs of equipment such as hospital beds or wheel chairs unless no other resource is available."

b. At hearing, the SCH amended sec. 1.655 C.4. to increase the maximum allowable cost per individual over a 12-month period from $7,500 to $10,000. The Department stated that this increase would enhance the program's ability to adequately serve a significant number of children whose costs of care fall over the current ceiling liability while not diminishing the program's capacity for providing some financial assistance to a large number of individuals.

c. The SCH has also proposed to amend sec. 1.655 E.4. as follows for the purpose of clarity: "Medical transportation, unless it is a medical emergency as determined by the medical director.

d. The Examiner finds that proposed sec. 1.655, as amended in paragraphs a., b. and c. above, is both needed and reasonable.

14. Proposed sec. 1.656, Administrative Review Procedures, establishes administrative procedures whereby an applicant may request a review of a decision regarding his/her eligiblity status or cost-sharing determination. This review may result in an appeal hearing before the State Office of Hearing Examiners if the applicant is dissatisfied with the SCH decision. The SCH has proposed to clarify the term "staff person" as follows: "An applicant and/or staff person of any agency may request . . ." The Examiner finds that proposed sec. 1.656, as amended above, is both needed and reasonable.

15. Proposed sec. 1.657, Responsibilities Between SCH and Service Providers, sets out the duties of each regarding the services provided to recipients and the reimbursement therefore. The SCH seeks to amend sec. 1.657 A.2. to specifically incorporate by reference the Medical Assistance Rates Schedule, revised September 7, 1978, established by the Minnesota

Department of Public Welfare. Approval for incorporation by reference was given on April 5, 1979 by Chief Hearing Examiner Duane R. Harves.

a. Mr. Aitchison and Mr. Norman of the Medical Center Rehabilitation Hospital both commented that sec. 1.657 A.4.a. does not recognize an appropriate accreditation body for rehabilitation centers. The SCH concurred with that concern and suggested that the language, or their appropriate accreditation body, be inserted in the section.

b. Dr. Robert Fitzgerald, D.C., commented that the proposed rules seem to be specifically tailored to medical doctors, osteopaths and dentists. Dr. Fitzgerald stated that the chiropractic profession should be listed as one of the providers with the same financial reimbursement privileges as the other medical profesisons. He points out that Minn. Stat. sec. 148.08, subd. 2, states that chiropractors have "all rights and privileges of other doctors or physicians in all matters pertaining to the public health. . . ." The SCH responded to Dr. Fitzgerald as follows:

> In response to Dr. Robert Fitzgerald, this Rule does not restrict the participation by any health care provider in Minnesota on the basis of specific licensure. By virtue of the special population of children served, SCH attempts to identify physicians, dentists, and other health professionals who by virtue of their training and experience demonstrated by licensure, appropriate board eligibility, registration or certification, have recognized ability and interest in serving the needs of these children with handicaps. Specialization of service and multi-disciplinary work setting are the two primary determinants in professional participation in SCH. This policy is consistent with Federal Guidelines for Crippled Children Services Programs.

c. The MMA commented that third-party reimbursement should be the responsibility of the applicant and not the service provider as spelled out in sec. 1.657 A.2.b.

d. The Examiner finds that proposed sec. 1.657, as amended in paragraph a. above, is both needed and reasonable.

16. The last page of the proposed rules contains an example of a cost-sharing determination for illustrative purposes.

Based upon the foregoing Findings of Fact, the Hearing Examiner makes the following:

C O N C L U S I O N S

1. The Department of Health gave due, timely and adequate legal notice of the hearing.

2. Pursuant to Minn. Stat. sec. 15.052, subd. 3 (1978), it is the duty of the Hearing Examiner to: ". . . (4) make a report on each proposed agency action . . . taking notice of the degree to which the agency has (i) documented its statutory authority to take the proposed action; (ii) fulfilled all relevant, substantive and procedural requirements of law or rule, and (iii) demonstrated the need for and reasonableness of its proposed action with an affirmative presentation of facts".

3. The Department of Health has statutory authority to promulgate the proposed rules.

4. The Department of Health has fulfilled all relevant, substantive and procedural requirements of law or rule.

5. The Department of Health has demonstrated the need for and the reasonableness of the proposed rules by an affirmative presentation of facts. The record does contain, however, many meritorious comments not spoken to in this Report which should be examined before final action is taken by the Department.

Based upon the foregoing Conclusions, the Hearing Examiner makes the following:

R E C O M M E N D A T I O N

That the Department of Health adopt the proposed rules as recommended to be amended herein.

Dated this 11 day of June, 1979.

Peter C. Erickson

PETER C. ERICKSON
Hearing Examiner

STATE OF MINNESOTA

COUNTY OF HENNEPIN

BEFORE THE MINNESOTA

COMMISSIONER OF HEALTH

In the Matter of Proposed Rules Relating to Family Planning Special Project Grants (7 MCAR § 1.457)

FINDINGS OF FACT, CONCLUSIONS AND ORDER

The above-entitled matter came on for hearing at 9:30 a.m. on January 10, 1979, in Room 105 of the Minnesota Department of Health Building, 717 Delaware Street Southeast, before Steve M. Mihalchick, Hearing Examiner. On February 21, 1979, the Hearing Examiner dated and submitted his report.

Based upon all the testimony, exhibits and written comments, and the Report of the Hearing Examiner, the Commissioner now makes the following:

FINDINGS OF FACT

1. The Commissioner adopts, as his own, the Findings of Fact contained in the Report of the Hearing Examiner of February 21, 1979 (hereinafter the "Report"), said Report being fully incorporated into and made a part of these findings as if set forth by the Commissioner, except that the Commissioner does adopt additional findings of fact as noted herein below.

2. The Commissioner agrees with the Hearing Examiner's recommendation in Finding of Fact #11 of the Report that a sentence be added either by way of an amendment to the proposed 7 MCAR § 1.457A or attached as a "comment" or "note."

3. The Commissioner agrees with the Hearing Examiner that information already contained in Minn. Stat. § 144.925 (1978) was of such import to many people that a paraphrase of statutory language should be published with the rules.

4. In order to convey the full meaning of Minn. Stat. § 145.925, subd. 4 (1978) and to prevent any possible misunderstanding on the part of the public, the Commissioner finds that the exception delineated in Minn. Stat. § 145.925, subd. 4 (1978) should be referenced in any clarifying statement published with the rules.

5. In accordance with Findings 2 through 4, herein, the following statement shall be included with the rules as finally adopted:

> Minn. Stat. § 145.925 contains provisions prohibiting use of these funds for abortions, family planning services to unemancipated minors in school buildings, requiring notice to parents or guardians of unemancipated minors to whom abortion or sterilization is advised, except as provided in Minn. Stat. §§ 144.341 and .342, and prohibiting coercing anyone to undergo an abortion or sterilization.

6. The Commissioner finds that the inclusion of the statement referenced in Finding of Fact #5, herein, is reasonable and necessary.

CONCLUSIONS OF LAW

The Commissioner adopts, as his own, the conclusions contained in the Report, said conclusions being fully incorporated and made a part of the Commissioner's conclusions as if set forth by the Commissioner.

ORDER

The rules relating to Family Planning Special Project Grants and identified as 7 MCAR § 1.457 are found to be reasonable, necessary and supported by the evidence contained in the records, and are hereby approved and adopted pursuant to the authority vested in me in Minn. Stat. §§ 145.925, subd. 5, 144.12, subd. 1, and 145.912, subd. 3 (1978) except that said rule shall be modified in accordance with the non-substantial change as set forth in the Commissioner's Findings of Fact.

Dated: March 1, 1979

STATE OF MINNESOTA

COMMISSIONER OF HEALTH

George R. Petterson M.D.

GEORGE R. PETTERSEN, M.D.
Commissioner of Health

HLTH-79-030-PE

STATE OF MINNESOTA
OFFICE OF HEARING EXAMINERS

FOR THE DEPARTMENT OF HEALTH

IN THE MATTER OF PROPOSED RULES)
RELATING TO CRIPPLED CHILDREN'S)
SERVICES CRITERIA, PROCEDURES)
AND RESPONSIBILITIES FOR ELIGI-)
BILITY, COST-SHARING AND REIM-)
BURSEMENT.)

REPORT OF THE
CHIEF HEARING EXAMINER

WHEREAS, a hearing was held on April 25, 1979, and April 27, 1979, before Peter C. Erickson, a Hearing Examiner of the State Office of Hearing Examiners, on the above-entitled matter in compliance with Minn. Stat. § 15.0412, subd. 4; and

WHEREAS, the Report of the Hearing Examiner made pursuant to Minn. Stat. § 15.052, subd. 3, was issued to the Department of Health on June 11, 1979; and

WHEREAS, the Department of Health has now determined to adopt rules pursuant to Minn. Stat. § 15.0412, subd. 4; and

WHEREAS, the Department of Health has submitted said rules to the Chief Hearing Examiner for review pursuant to Minn. Stat. § 15.052, subd. 4, and Rule 9 MCAR § 2.110; and

WHEREAS, the Chief Hearing Examiner finds that the final proposed rules are not substantially different from those proposed at the public hearing and that the Department of Health has met all requirements of Minn. Stat. § 15.0412, subd. 4.

NOW, THEREFORE, upon receipt of this Report, the Department of Health has the responsibility of submitting the complete hearing record and the rules as adopted by the Department to the Attorney General, notifying all persons who requested to be informed that the hearing record has been submitted to the Attorney General, and publishing in the State Register, all pursuant to Minn. Stat. § 15.0412, subd. 4.

Dated this 10th day
of September, 1979.

Duane R. Harves

DUANE R. HARVES
Chief Hearing Examiner

STATE OF MINNESOTA

OFFICE OF HEARING EXAMINERS

FOR THE MINNESOTA DEPARTMENT OF HEALTH

In the Matter of the Proposed Rules Relating to Crippled Children Services Criteria, Procedures and Responsibilities for Eligibility, Cost-Sharing and Reimbursement

REPORT OF THE CHIEF HEARING EXAMINER RELATING TO INCORPORATION BY REFERENCE

Pursuant to Minn. Stat. § 15.0412, subd. 4 (1978), the Minnesota Department of Health, on March 30, 1979, requested approval of the Chief Hearing Examiner to be allowed to incorporate by reference a document in the above-entitled proposed rules. This document is entitled, "Medical Assistance Rate Schedule, Revised September 7, 1978." This rate schedule has been established by the Minnesota Department of Public Welfare under its authority found in 12 MCAR § 2.047.

The Chief Hearing Examiner, having reviewed this document, has found that it exceeds 3,000 words in length and would exceed five printed pages in the Minnesota State Register. Additionally, the Chief Hearing Examiner finds that this document is at the Minnesota Department of Health, is an official record under Minn. Stat. § 15.17 (1978) and, therefore, must be under Subdivision 4 of that law, " . . . easily accessible for convenient use." Furthermore, this document is available at all county welfare departments.

NOW, THEREFORE, the Chief Hearing Examiner herewith gives approval to the Minnesota Commissioner of Health for the incorporation by reference of the above-entitled document in the proposed rules relating to crippled children services criteria, procedures and responsibilities for eligibility, cost-sharing and reimbursement.

Dated this 5th day of April, 1979.

DUANE R. HARVES
Chief Hearing Examiner

STATEMENT OF COMPLIANCE WITH

MANUAL OF RULE MAKING PROCEDURES

I, Special Assistant Attorney General Terry P. O'Brien, do hereby declare that I have examined the proposed rules relating to Criteria, Procedures and Responsibility for Eligibility for Cost-Sharing and Reimbursement of Services for Children With Handicaps and all related documents and that, based on such examinations and my personal familiarity with the applicable procedures, the Manual of Rule Making Procedures has been followed.

Dated: October 12, 1979

TERRY P. O'BRIEN
Special Assistant
Attorney General